

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

109581

Reg. Dist. No. 245

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Syattsville Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md County Prince George  
 City or town Syattsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 5563 - 43 place  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Joyce Audrey Abel

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

single

## 6. (b) Name of husband or wife.

## 7. Birth date of deceased (mo., day, yr.)

Feb 27, 1928

## 6. (c) If alive, give age. years

## 8. AGE:

20 Years Months Days If less than one day

## 9. Birthplace

Washington

## 10. Usual occupation

Student

## 11. Industry or business

Philip Abel

## 12. Name

## 13. Birthplace

## 14. Maiden name

## 15. Birthplace

## 16. Informant

Philip Abel

## Address

Burial

## (Burial, cremation, or removal. Which?)

Date thereof

## Cemetery or crematory

St. Lincoln

## Location

Colmar Manor Md

## 18. Funeral director

F. Bascie sons

## Address

Syattsville Md

## 19. (Date rec'd by registrar)

Sept 14 1948 James Berry

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 9/10/48 19 10 at 1/2 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/15/36 19 9/10/48 19 9/10/48 19  
 and that I last saw him alive on 9/10/48 19

## Immediate cause of death

congestive heart failure  
carcinoma of rectum

## Due to

## Due to

## Other conditions

—

(Include pregnancy within 3 months of death)

Major findings of operations carcinoma of rectum  
 Date of op. 8/17/48

## Autopsy results

none done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

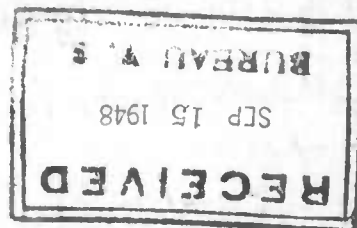
Accident, suicide, or homicide. — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE Dr. J. B. Smith, M.D. M. D. or otherAddress 811-8-N.E. Date signed 9/10/48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09582

Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County Prince George

City or town Decatur Heights  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? One week

Hospital, institution, or street address where death occurred

5105- Lippshur Street

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Decatur Heights  
(If outside city or town limits write RURAL and give nearest town)

Street No. 5105- Lippshur St.

(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

Percy Clair Bambier

## 3. (b) Social Security Number

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Married.

6. (b) Name of husband or wife

Agnes Bambier

7. Birth date of

deceased (mo., day, yr.)

Mar 11, 1893

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

55

6

11

hrs.

min.

9. Birthplace

Washington, D.C.  
(Town, county, or state)

10. Usual occupation

Supervisor Capital Transit Co

11. Industry or business

Public Utility

12. Name

Edward G. Bambier

13. Birthplace

Washington, D.C.

14. Maiden name

Artie Amey

15. Birthplace

Washington, D.C.

16. Informant

Robert Bambier

Address

5413 - Gallatin St. Rogers Mt

17.

Removal  
(Burial, cremation, or removal. Which?)

Date thereof

Sept 22-48  
(month) (day) (year)

Cemetery or crematory

Location

Washington, D.C.

18. Funeral director

Address

W. W. Chambers Co.  
17-1154 St. S.E. Wash. D.C.

19.

Sept 22, 1948  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 22 1948 at 5:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death

Acute Coronary Occlusion

DURATION

Sudden

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John J. Maloney, Dep. Med.  
M. D. or other  
Address Chertsey Hyattsville  
Date signed 9-22-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09583

Reg. Dist. No. 239

1. PLACE OF DEATH  
 County..... Prince George's  
 City or town..... Laurel, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 2 yrs  
 Hospital, institution, or street address where death occurred:  
 Davis Home for children  
 How long in hospital or institution?..... about 2 yrs

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County..... Prince Geo's  
 City or town..... Laurel, Md (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... R. H. D. #2  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Jennie Mae Bartlett

## 3. (b) Social Security Number

4. Sex..... female  
 5. Color or race..... white  
 6. (a) Single, married, widowed, or divorced..... single baby

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... 3/3/46  
 6. (c) If alive, give age..... years

8. AGE: Years..... 2 Months..... 5 Days..... hrs..... min.

9. Birthplace..... Baltimore City Hospital  
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant..... Mrs Mary Davis

Address..... Laurel, Md

17. Burial..... Date thereof..... Sept 3, 1948

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory..... Ivy Hill Cemetery

Location..... Pr. Geo's Laurel, Md

Funeral director..... W. R. Selby

Address..... 401 Washington Blvd Laurel, Md

19. Self - 1948

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 9 - 1 1948 at 5:50 am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

8 31 1948 to 9 1 1948

and that I last saw him alive on 9 1 1948

Immediate cause of death.....

Broncho Pneumonia

malnutrition

Due to.....

mental defect

under development

Due to.....

Stomach's

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... B. B. Plummer

M. D. or other.....

Address..... Laurel, Md Date signed..... 9-3-48

RECEIVED

SEP 8 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09584

Reg. Dist. No. 242

1. PLACE OF DEATH: Pr. Geo. Co.  
County.....  
City or town..... Capital Heights, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 46  
Hospital, institution, or street address where death occurred:  
403 - 50th Ave  
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Pr. George  
City or town..... Capital Heights  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 403 - 50th Ave  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3. (a) FULL NAME James William Beavers  
3. (b) Social Security Number.....

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of ~~husband~~ wife Sarah Catherine Beavers  
6. (c) If alive, give age 77 years  
7. Birth date of deceased (mo., day, yr.) Feb 8 1871  
8. AGE: Years 77 Months Days If less than one day  
hrs. min.

9. Birthplace Navy, Fairfax Co., Va.  
(Town, county, and state)  
10. Usual occupation Salesman  
11. Industry or business Sewing Machine  
12. Name James Thomas Beavers  
13. Birthplace Waxpoole Va  
14. Maiden name Mary Anne Kidwell  
15. Birthplace Vienna Va

16. Informant Mrs Sarah Catherine Beavers  
Address 403 - 50th Ave

17. Burial Date thereof 9-6-48  
(Burial, cremation, or removal, Which?)  
Cemetery or crematory Cedar Hill Cemetery  
Location Suitland Pr. Geo. Co Md  
18. Funeral director W. W. Chambers & Co  
Address 577-11th St SE

19. Sept 5 1948 Carrie F. Campbell  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH September 3 1948 at 2:30 AM  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
September 15 1946 to Sept 3 1948  
and that I last saw him alive on Sept 2 1948  
Immediate cause of death Cerebral hemorrhage  
DURATION 36 Hours  
Due to Generalized arteriosclerosis 3 Yrs.  
(History)  
Due to Senility  
Other conditions  
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....  
Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of.....  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

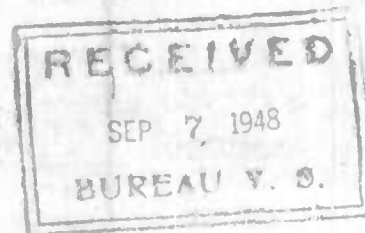
23. SIGNATURE W. Smit- Ritchie M.D.  
M. D. or other  
Address 6906 Ritchie Rd SE Date signed 9/3/48  
Wash 19 D.C.

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 142

### 1. PLACE OF DEATH:

County PRINCE GEO  
City or town HILLSIDE MD.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 19 YRS.  
Hospital, institution, or street address where death occurred:  
  
How long in hospital or institution? —

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MD. County PRINCE GEO  
City or town HILLSIDE MD.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 5603 - L - ST.  
(If rural, give LOCATION)  
2. (a) If veteran, name war —

### 3. (a) FULL NAME

SUSIE D. BROWNE

### 3. (b) Social Security Number

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced MARRIED  
6. (b) Name of husband or wife FLOYD - BROWNE  
7. Birth date of deceased (mo., day, yr.) July 12<sup>th</sup> 1892  
8. AGE: Years 56 Months — Days — If less than one day — hrs. — min. —

9. Birthplace CHL PEPPER - VA.  
(Town, county, and state)

10. Usual occupation HOUSE WIFE

11. Industry or business NONE

12. Name JAMES ROBERTS

13. Birthplace VA.

14. Maiden name MARY - DEMPSEY

15. Birthplace VA.

16. Informant FLOYD - BROWNE

Address 5603 - L - ST, HILLSIDE MD.

17. Burial Date thereof 9-13-48  
(Burial, cremation, or removal) Which? (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Shirland md.

18. Funeral director W. W. Chambers Co

Address 517 11<sup>th</sup> St S.E

19. Sept. 10 19 48 Carrie E. Campbell  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 19 48 at 1:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 15 19 46 to Sept 4 19 48  
and that I last saw him alive on September 4 19 48

Immediate cause of death Coronary Thrombosis DURATION suddenly

Due to arteriosclerotic heart disease 10 years

Due to Diabetes Mellitus 10 years

Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

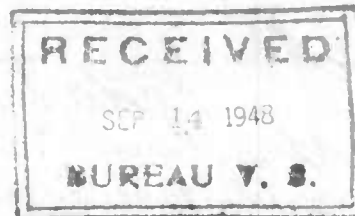
23. SIGNATURE W. Suit Ritchie MD  
6906 Ritchie Road SE M. D. or other 9/10/48  
Address Washington 19 D.C. Date signed

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr Jas I Boyd was  
called + in view of  
fact she had been  
under my care for a  
long period and was  
seen five days ago  
permission was given  
to sign certificate  
W. S. Pelton



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 09586-45

### 1. PLACE OF DEATH:

County Puna George

City or town Int. Rainier  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

3704-34th St.

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Puna George

City or town Int. Rainier  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3704-34th St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Hazel Clifford Burriss

### 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Divorced

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

June 19, 1901

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

47

hrs.

min.

9. Birthplace

Maryland  
(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

Capital view Real estate Co

12. Name

Arthur Burriss

13. Birthplace

Maryland

14. Maiden name

Annie Spots

15. Birthplace

Maryland

16. Informant

Mrs Eva M Carpenter

Address

3704-34th Int Rainier Md

17.

Burial  
(Burial, cremation, or removal. Which?)

Date thereof Sept 22, 1948  
(month) (day) (year)

Cemetery or crematory

St. Lincoln

Location

Colmar Manor Md

18. Funeral director

F. Gasche Sons

Address

Hyattsville Md.

19.

Sept 22  
(Date rec'd by registrar)

19.

44 James Sever

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18 1948 at 11:59 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 12 1948 to September 18 1948 and that I last saw him alive on September 18 1948

Immediate cause of death

Cerebral Hemorrhage

DURATION

4.8 hrs.

Due to

Due to

Other conditions

Chronic Myocarditis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Harry J Crawford MD

M. D. or other

Address

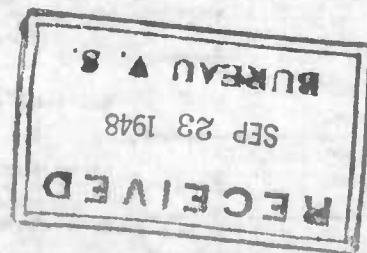
816-E St NE Wash DC

Date signed Sept 19, 48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

163M

09587

Reg. Dist. No. 245

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Berwyn Heights  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State New York County Cattaraugus

City or town Cattaraugus  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 207-3ompson St  
 (If rural give LOCATION)

2.(a) If veteran, name war World War II ✓

## 3. (a) FULL NAME

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Catherine Campbell6.(c) If alive, give age 37 years7. Birth date of deceased (mo., day, yr.) Jan 4, 1915

8. AGE: Years 33 Months 8 Days 15 It less than one day hrs. min.

9. Birthplace Binghamton, N.Y.  
(Town, county, and state)10. Usual occupation Soldier

11. Industry or business

12. Name Frank Campbell13. Birthplace Wadena, Iowa14. Maiden name Lena Smith15. Birthplace New York19. Informant Richard H. HodgeAddress Cattaraugus, N.Y.removal Sept 22, 1948

(Burial, cremation, or removal. When?)

Cemetery or crematory Washington McLocation Exochorda sons19. Funeral director Exochorda sonsAddress Exochorda sonsDate rec'd by registrar Sept 22 1948

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1948 at Berwyn Heights

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on Sept 19Immediate cause of death Asphyxia carbonicaDue to Inhalation of fumes from auto. exhaust

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of Sept 19, 48Where did injury occur? Berwyn Heights (City or town) (State)Injured at home, farm, industry, public place (where?) off Public HighwayMeans of injury Asphyxia Injured at work? No23. SIGNATURE John J. Maloney Examiner M.D. or otherAddress Exochorda sons Date signed 9-20-48

**RECEIVED**

SEP 25 1948

**BUREAU V. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 09588-23

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Shirley House - Washington 1900  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Since Feb 11 1948  
 Hospital, institution, or street address where death occurred:  
Shirley House Road, Ritchie, Md.  
 How long in hospital or institution? 7 mo

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges Co  
 City or town Upper Marlboro Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 701 - Shirley House Rd.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war no

## 3. (a) FULL NAME

Joseph B Carter

## 3. (b) Social Security Number

unknown4. Sex male 5. Color or race negro 6. (a) Single, married, widowed, or divorced singleB. (b) Name of husband or wife unknown7. Birth date of deceased (mo., day, yr.) unknown 1878 B. (c) If alive, give age — years8. AGE: Years 70 Months unknown Days unknown If less than one day — hrs. — min.9. Birthplace Prince Georges Co. Md  
(Town, county, and state)10. Usual occupation laborer

## 11. Industry or business

12. Name Robert Carter13. Birthplace Maryland14. Maiden name Maey unknown15. Birthplace unknown16. Informant Deceased History RecordAddress —17. Burial — Date thereof Sept 21 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. CarmelLocation Upper Marlboro, Md.18. Funeral director Ritchie Bros.Address Upper Marlboro, Md.19. Sept 20 48 R. B. Carter  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1948 at 2 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1948 to Sept 19 1948 and that I last saw him alive on Sept 18 1948Immediate cause of death Heart DiseaseDue to Chronic Coronary Disease 1 dayand Chronic Bronchitis unknownDue to — unknownOther conditions General Arterio- unknownsclerosis —

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Natural Cause Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Robert Carter M. D. or otherAddress Washington 1900 Date signed Sept 19 1948







PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 242

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Rural - Washington 20 DC  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges  
 City or town Washington 20 DC  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 5550 Oxon Hill Rd SE  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war World War # II

## 3. (a) FULL NAME

George Valley Cox  
 4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Single

## 3. (b) Social Security Number

577-03-9738

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 1948, at 5:10 P.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 6 1948 to Sept 12 1948  
 and that I last saw him alive on Sept 11 1948

## Immediate cause of death

Cirrhosis of Liver

## DURATION

unknown

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions none of note - amputation  
of leg about 4 weeks and early rot foot - possibly  
injury during war.  
 (Include pregnancy within 3 months of death)  
 Major findings of operations. \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results. \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following: \_\_\_\_\_

Accident, suicide, or homicide. \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

## 23. SIGNATURE

George Valley Cox  
5440 Silver Hill SE  
Washington 20 DC  
 Address \_\_\_\_\_ Date signed Sept 12 1948

## 6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Dec. 19 1915

8. AGE: Years 32 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Oxon Hill Md.  
 (Town, county, and state)

10. Usual occupation none11. Industry or business none

FATHER 12. Name George Valley Cox  
 13. Birthplace Md.

MOTHER 14. Maiden name Helen Berry  
 15. Birthplace Wash. DC

16. Name Mrs Helen E. Cox Sr  
 Address 5550 Oxon Hill Rd.

17. Burial Date thereof 9-15-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington Natl.  
 Location Arlington Va.

16. Funeral director W. W. Chambers &  
 Address 517 11th St S.E.

19. Sept. 13 1948 Carrie F. Campbell  
 (Date rec'd by registrar) Registrar



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 230

## 1. PLACE OF DEATH:

County Prince George  
City or town Beltsville, Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 years  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

John Henry Crump

## 3. (b) Social Security Number

## 4. Sex

male

## 5. Color or race

Cal.

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Lottie

## 7. Birth date of deceased (mo., day, yr.)

About 18746. (c) If alive, give age 71 years

## 8. AGE:

Years 74 Months 1 Days 7 If less than one day  
hrs. min.

## 9. Birthplace

Beltsville  
(Town, county, and state)

## 10. Usual occupation

Janitor

## 11. Industry or business

Isreal Crump

## 12. Name

Louden Co. Va.

## 13. Birthplace

Elizabeth Wales

## 14. Maiden name

Md.

## 15. Birthplace

John Henry Crump, Jr.

## 16. Informant

Beltsville, Md.

## 17. Burial

Queen's Chapel

## 18. Cemetery or crematory

Prince George Co. Md.

## 19. Location

Henry S. Washington & Sons

## 20. Funeral director

467-N ST. N.W. Wash. D.C.

## 21. Address

Sept -16- 1948

## 22. (Date rec'd by registrar)

John D. Smith

## 23. Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Prince GeorgeCity or town Beltsville  
(If outside city or town limits, write RURAL and give nearest town)Street No. Beltsville  
(If rural, give LOCATION)

## 2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 1948 at 10:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 19 1948 to Sept 15 1948and that I last saw him on Sept 9 1948Immediate cause of death Coronary Artery DURATION 1 yrwith atherosclerosisDue to with atherosclerosis

Due to

Other conditions arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. M. Warren M.D.Address Franklin Md. 9/15/48

Address

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

09591

231

## 1. PLACE OF DEATH:

County Prince George'sCity or town Cheverly, Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 hours 28 min.

Hospital, institution, or street address where death occurred:

Prince George's General HospitalHow long in hospital or institution? 5 hours 28 min.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town District Heights  
(If outside city or town limits, write RURAL and give nearest town)Street No. 209 Elmhurst Street

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

Dean, Baby Girl SUE ANN

## 3.(b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Fe

W

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1948

8. AGE: Years Months Days If less than one day

5 hrs. 28 min.9. Birthplace Cheverly, Prince Georges Md.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Luther M. Dean13. Birthplace DC ANASCOSTIA, MD.14. Maiden name Shirley Farr15. Birthplace DC

16. Informant

Address

17. Cremation Date thereof Sept 13 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Prince Georges General HospLocation Cheverly, Md18. Funeral director Harry W Penn Jr, Ret. SuptAddress Cheverly, Md19. 9/15 48 Amanda Downey  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10, 1948 19. at 10:20 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9/10 19. 48 to 9/10 19. 48and that I last saw him alive on 9/10/48Immediate cause of death prematurity DURATIONDue to maternal diabetes andimpending coma

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

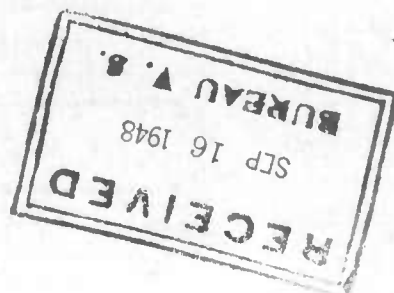
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE T. A. Chung Versen, M.D. M. D. or otherAddress College Park, Md Date signed 9/10/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09592

Reg. Dist. No. 242

## 1. PLACE OF DEATH:

County... Pr. Geo.City or town... Rural Croon, Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... P. Geo.City or town... Rural Croon  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1/2 mi. east  
(If rural, give LOCATION)

2.(a) If veteran, name war:

## 3. (a) FULL NAME

Chloe Johnson Higgins

## 3. (b) Social Security Number

4. Sex

F.

5. Color or race

C.

6. (a) Single, married, widowed, or divorced

M.

B. (b) Name of husband or wife

John Higgins

7. Birth date of deceased (mo., day, yr.)

Mar 29, 19006. (c) If alive, give age 55 years

8. AGE:

55

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Pr. Geo.  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Lemuel Funnigan

13. Birthplace

P. Geo. Co.

MOTHER

14. Maiden name

Mary Ann Stewart

15. Birthplace

P. Geo. Co.

18. Informant

Address

John Higgins  
Croon, Md.

17.

(Burial, cremation, or removal, which?)

Date thereof

Sept 27, 1948  
(month) (day) (year)

Cemetery or crematory

St. Mary's Cemetery

Location

Croon, Md.

18. Funeral director

Address

John T. Stewart  
301 H. St. N.E.

19.

(Date rec'd by registrar)

Sept. 24, 48Carrie F. Campbell

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 19 48, at 11:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 12, 46 19... to Sept 23 19 48and that I last saw him alive on 20 Sept 19 48

Immediate cause of death

Uremia

DURATION

3 wks.Due to Hypertensive CrisisVasculopathy of Aorta

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please indicate the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R. J. Fanner

M. D.

Address Upper Marlboro, Md. Date signed 24 Sept 48



RECEIVED

SEP 28 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The contents of this page is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09593

Reg. Dist. No. 237

## 1. PLACE OF DEATH:

County Prince GeorgeCity or town Aguasco  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 mos

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County PRINCE GEORGECity or town AGUASCO  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

DOUGLAS, JOHN FRANCIS Douglas

## 3.(b) Social Security Number

4. Sex M5. Color or race C6.(a) Single, married, widowed, or divorced S

6.(b) Name of husband or wife \_\_\_\_\_

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) 27 APRIL 19488. AGE: Years \_\_\_\_\_ Months 5 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Aguasco, Prince George Co. Md.  
(Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Robert Douglas13. Birthplace Aguasco, Md.14. Maiden name Mary Thomas15. Birthplace Charles Co Md16. Informant MotherAddress Aguasco Md17. Buried Date thereof Sept 27/48  
(Burial, cremation, or removal. When?) (month) (day) (year)Cemetery or crematory St. Mary's Church Cem.Location Bryantown, Md.18. Funeral director Eugene C. DavisAddress Aguasco Md.19. Sept 27th 1948 Mrs H.B. Cantie  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 26 Sept. 19 48 at 7:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2:30 P.M. 26 Sept. 48 to 4:48and that I last saw him alive on 26 Sept. 19 48

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Asphyxia due to aspiration ofDue to emesis -

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Roy Guther, M.D.Address Georgetownville, Md. M. D. or other \_\_\_\_\_Date signed 27 Sept 48

**RECEIVED**

SEP 30 1948

**BUREAU V. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09594

Reg. Dist. No. 243

## 1. PLACE OF DEATH:

County Prince GeorgesCity or town Glen Dale  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Glen Dale  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)2. (a) If veteran, name war Spanish American

## 3. (a) FULL NAME

William Howard Downey

## 3. (b) Social Security Number

## 4. Sex

male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

married

## 6. (b) Name of husband or wife

Helen Downey

## 7. Birth date of deceased (mo., day, yr.)

Apr. 14, 1893

## 6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

65

\_\_\_\_\_ hrs. \_\_\_\_\_ min.

## 9. Birthplace

Lynn, Mass  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

Roslaw Nursery

## FATHER

## 12. Name

Thomas F. Downey

## 13. Birthplace

Ireland

## MOTHER

## 14. Maiden name

Hannah Allen

## 15. Birthplace

Ireland

## 16. Informant

Henry J. Downey

## Address

230-Hurst Ave. - E. Lansdowne Pa.17. Burial

(Burial, cremation, or removal, which?)

## Date thereof

Sept. 17, 1948  
(month) (day) (year)

## Cemetery or crematory

Arlington Nat.

## Location

Arlington Va.

## 18. Funeral director

F. J. Basko Sons

## Address

Bladensburg Md19. 9/17

(Date rec'd by registrar)

19 48Annals Downey  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 19 48 at 2:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19 \_\_\_\_\_, to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

## Immediate cause of death

Coronary Occlusion

## DURATION

Sudden

## Due to

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

\_\_\_\_\_ Date of op. \_\_\_\_\_

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

## Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

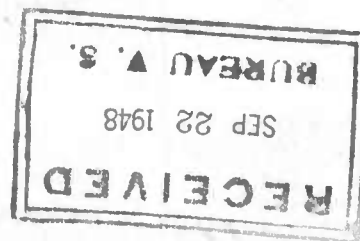
## 23. SIGNATURE

John J. Maloney Exp. med.

M. D. or other

## Address

Cherry - HyattsvilleDate signed 9-13-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

09596

231

## 1. PLACE OF DEATH:

County Prince George's County  
 City or town Chesley, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Prince George's General Hospital  
 How long in hospital or institution? 5 months

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Pro Geo  
 City or town Hyattsville MD  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4104 Ogden St  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

 Fletcher, William

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

m w married

6. (b) Name of husband or wife Jane Fletcher7. Birth date of deceased (mo., day, yr.) August 14, 1879

8. AGE: Year Month Day If less than one day

69 hrs. min.

9. Birthplace New York  
(Town, county, and state)10. Usual occupation Retired - U.S. Govt11. Industry or business Left Commerce12. Name John Fletcher13. Birthplace N.Y.14. Maiden name Mary Holcum15. Birthplace N.Y.16. Informant John M. FletcherAddress 2713 Branch Ave Washington17. Cremation Date thereof Sept 20, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Cedar HillLocation Hyattsville MD18. Funeral director F. Pasche sonsAddress Hyattsville MDDate rec'd by registrar Sept 25 48Registrar James Beery

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/24 19 48 2:19 p21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 4-22 19 48 to 9/24 19 48and that I last saw him alive on 9-24-48 19 48

Immediate cause of death

DURATION

CarcinomaDue to of BladderDue to enlargedOther conditions metastasis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. J. Beery M. D. or otherAddress Hyattsville MD Date signed Sept 25 48

RECEIVED

SEP 29 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County: Prince George's  
 City or town: Cheverly, Md.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 da 11 hr. 35 min.

Hospital, institution, or street address where death occurred:

Prince George's General HospitalHow long in hospital or institution? 1 da 11 hr. 35 min.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: DC County: \_\_\_\_\_City or town: Washington  
 (If outside city or town limits, write RURAL and give nearest town)Street No. 9 Girard St., N.E.  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Jo Ann Foreman

## 3. (b) Social Security Number

4. Sex

Fe

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Baby

6.(b) Name of husband or wife \_\_\_\_\_

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of

deceased (mo., day, yr.)

Aug. 18, 1948

8. AGE:

YearsMonthsDays

If less than one day

26 days26hrs.min.9. Birthplace: Washington, D.C.  
 (Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

FATHER

12. Name: Edward Foreman13. Birthplace: Norfolk Va.

MOTHER

14. Maiden name: Elizabeth Brown15. Birthplace: D.C.16. Informant: Edward L. Foreman

Address

9 Girard St NE17. Burial  
 (Burial, cremation, or removal. Which?)Date thereof: Sept 15, 1948  
 (month) (day) (year)

Cemetery or crematory

Congressional Cemetery

Location

Wash. Sta. D.C.

18. Funeral director

J. O. Lee Sons Co.

Address

300 - 4th St NE19. Sept 14, 1948  
 (Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 13, 1948 19\_\_\_\_ at 12:10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9/91948to 9/131948and that I last saw h. see alive on 9/131948

Immediate cause of death

acute  
retroperitoneal  
tumour  
cause unknown

DURATION

?

Due to \_\_\_\_\_

?

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_

Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

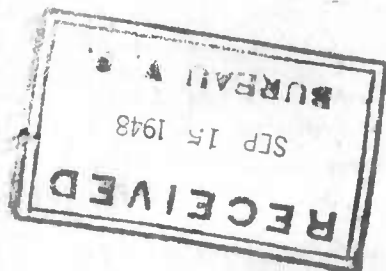
Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE: T. A. Christensen

M. D. or other

Address: College Park, Md.Date signed: 9/13/48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

09598

245

## 1. PLACE OF DEATH:

County... Prince Geo. Co.  
 City or town... Riversdale  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 44 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MD County... Pr. Geo. Co.City or town... Riversdale  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4913 Ravenwood Rd  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Bertha Marie Gaither

## 3. (b) Social Security Number

4 Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

married6.(b) Name of husband or wife... Benjamin H. Gaither

1. Birth date of deceased (mo., day, yr.)

July 21 - 1876

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

72

hrs.

min.

9. Birthplace

Baltimore - MD  
(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

MOTHER FATHER

12. Name

Ferdinand Wm Hewett

13. Birthplace

MD

14. Maiden name

Albertine Sheseder

15. Birthplace

MD

16. Informant

Benjamin H. Gaither

Address

4913 Riversdale Rd. Riversdale, MD

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Burial Sept 25 - 48

Cemetery or crematory

Landon Park Cemetery

Location

Baltimore - MD

18. Funeral director

W W Chambers Co

Address

Riversdale, MD

19.

(Date rec'd by registrar)

19 48Wm Jas Severe  
Deputy Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 23 -19 48

at

145  
9 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 419 44Sept 23 19 48

and that I last saw him alive on

Sept 1619 48

Immediate cause of death

Bronchial Asthma

DURATION

52 years

Due to

Due to

Other conditions

General arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

L W Zelman MD

M. D. or other

Address

Riversdale, MD

Date signed

9-23-48

RECEIVED

SEP 25 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully. Inc. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 230

## 1. PLACE OF DEATH:

County Prince GeorgesCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

On Highway Rt # 1

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BaltimoreCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 109 CHAPEL ST.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

GEORGE (W) ENGLE

## 3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

WIDOWED6. (b) Name of husband or wife BARBARA ENGLE

7. Birth date of deceased (mo., day, yr.)

JANUARY 1881

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

678

hrs.

min.

9. Birthplace

BALTIMORE, MD  
(Town, county, and state)

10. Usual occupation

LABORER

11. Industry or business

MOTHER FATHER

12. Name

CHARLES ENGLE

13. Birthplace

GERMANY

14. Maiden name

HY MENA

15. Birthplace

GERMANY16. Informant BROTHER - FRED ENGLE

Address

2318 CAMBRIDGE ST. BALTIMORE

17. (Burial, cremation, or removal. Which?)

BURIAL

Date thereof

9-3-48  
(month) (day) (year)

Cemetery or crematory

MT CARMEL, BALTIMORE

Location

18. Funeral director

WILLIAM COOK INC

Address

ST. PAUL + PRESTON ST, Baltimore, MD

19. (Date rec'd by registrar)

September 1st 194819. 48

Registrar

23. SIGNATURE

Address

John D. Smith  
Chesley, Md

Dep. M.D. Examiner

Date signed 9-1-48

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 1948 at 1:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death

Fracture dislocation of 7 on Cervical vertebra

DURATION

Sudden

Due to.....

Due to.....

Other conditions

Fracture of left femur  
(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

AccidentDate of Sept 1, 1948

Where did injury occur?

U.S. Rt 1 Bethesda Pr. Geo. Md.  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Public Highway

Means of injury

Struck by tractor trailerInjured at work? NO

**RECEIVED**

SEP 7 1948

**BUREAU V. W.**

DR. N. B. STEWARD

322 Prince George Street

LAUREL, MARYLAND

To Whom it may concern:-

I have this day -  
as 2:15 Examined - a  
unknown man, and found  
him dead. cause of death  
fractured neck, and lungs  
etc.

Lynd

W. B. F.

Expts 1-48



Dr. Maloney

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

231

## 1. PLACE OF DEATH:

County Prince George  
 City or town Chesapeake  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 16 days  
 Hospital, institution, or street address where death occurred:  
Prince George Hosp  
 How long in hospital or institution? 16 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Pr. George  
 City or town Lanham  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Gaither, Dr. Frederick W

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Hortense  
 7. Birth date of deceased (mo., day, yr.) Sept 25, 1874  
 8. AGE: Years 76 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Howard Co. Md  
 (Town, county, and state)

10. Usual occupation Builder

11. Industry or business \_\_\_\_\_

12. Name Henry Gaither

13. Birthplace and

14. Maiden name Susan Wayfield

15. Birthplace and

16. Informant Hortense McH. Gaither

Address "Hope Home" Lanham and

17. and Date thereof 9-16-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fort Lincoln Cmty

Location Calver Manor and

18. Funeral director Wardlaw &

Address Princedale and

19. 9/16 19 48 Amanda Conway  
 (Date recorded by registrar) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH Sept 13 19 48 at 3:05 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 19 19 48 to Sept 13 19 48

and that I last saw him alive on Sept. 13 19 48

Immediate cause of death Carcinoma of Prostate

Due to Operation - Sept. 1, 1948 - Metastases

Due to \_\_\_\_\_

Other conditions Psychitis R. mental

obstruction metastatic

pelvic lymph nodes - R. retroperitoneal masses

Major findings of operations Psychitis R. mental

R. mental obstruction

metastases

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Albert Rath, M.D.

Address Lanham Md Date signed 9/13/48

BUREAU A. S.

SEP 17 1948

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09660

Reg. Dist. No. 245

### 1. PLACE OF DEATH:

County Prince George  
City or town mt. Rainier Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 mo. 21 days.  
Hospital, institution, or street address where death occurred:  
Mrs. Bell Nursing Home  
How long in hospital or institution? 4 mths. 21 da.

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Wash. County D.C.  
City or town Wash. D.C.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. # 9 Flag Green S.W.  
(If rural, give LOCATION)  
2.(a) If veteran, name war ✓

### 3. (a) FULL NAME

Beatrice Ann Gardner

### 3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Mar 17, 1948 6.(c) If alive, give age 45 years

8. AGE: Years 5 mos Months 23 Days hrs. If less than one day

9. Birthplace Navy Medical Base Bethesda Md.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Joseph D. Gardner  
13. Birthplace Abaca Pa.

14. Maiden name Winnie Lou Potts  
15. Birthplace Will's Bars N.C.

16. Informant Mrs. Enzett Bell  
Address 3209 Perry St.

17. Burial Date thereof Sept 10, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Arlington Cemetery  
Location Arlington Va.

18. Funeral director Wm. J. Hall  
Address 3200 - P.D. Ave. Mt. Rainier

19. Sept. 9, 1948 Mrs. Jas. Sever  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 9-9 19 48 at 3:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 45 to Sept 9 19 48  
and that I last saw him/her alive on 9-3-48

Immediate cause of death

Hydrocephalus Senile Birth

Due to

Other conditions Spina Trifida Birth

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE John D. Maloney M.D. or other

Address Cherry Hyattsville Date signed 9-9-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09601

Reg. Dist. No.

231

## 1. PLACE OF DEATH:

County Prince Georges CountyCity or town Chesley, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Prince Georges General Hospital -

How long in hospital or institution?

1 1/2 wks.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County ChesleyCity or town Chesley  
(If outside city or town limits, write RURAL and give nearest town)Street No. 6126 Montrose Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

W.W. # I

## 3. (a) FULL NAME

Glazer, George B.

## 3. (b) Social Security Number

4. Sex

m.

5. Color or race

w.

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Jonna Glazer

7. Birth date of deceased (mo., day, yr.)

Sept

6.(c) If alive, give age years

1899

8. AGE:

Years

Months

Days

If less than one day

49

hrs.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual occupation

clerk

11. Industry or business

U.S. govt.

MOTHER

FATHER

12. Name

Harry Glazer

13. Birthplace

Russia

14. Maiden name

Rose Brown

15. Birthplace

Russia

16. Informant

Jonna Glazer

Address

6126 Montrose Rd. Chesley, Md.

17.

Sept 28-48  
(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Arlington National

Location

Arlington, Va.

18. Funeral director

B. Damansky + Son

Address

3501-14th St. N.W.

19.

9/24 48  
(Date rec'd by registrar)48Annanta Dorney

Registrar

23. SIGNATURE

George J. Hagen

M. I. or other

Address

3717 - 38th Ave

Date signed

9/24/48

## MEDICAL CERTIFICATION

20. DATE OF DEATH

9/24/48

19

at

2 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan151946to 9/241948

and that I last saw him alive on

9/241948

Immediate cause of death

Coronary infarctionrecurrentDue to Angina Pectoris

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

George J. Hagen

M. I. or other

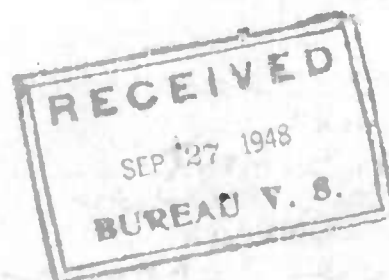
Address

3717 - 38th Ave

Date signed

9/24/48

1948  
~~1947~~  
1947



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 09602 240

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Brandywine  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 7 years  
 Hospital, institution, or street address where death occurred:  
Brandywine, Md.  
 How long in hospital or institution? 2 yrs.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md. County Prince Georges  
 City or town Brandywine, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war No

## 3. (a) FULL NAME

Fielder Clodious Greer

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Catherine E. Greer  
(nee Richards) 6. (c) If alive, give age 51 years  
 7. Birth date of deceased (mo., day, yr.) May 2, 1886  
 8. AGE: Years 62 Months 4 Days 6 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Pr. Geo. Co., Md.  
 (Town, county, and state)

10. Usual occupation Retired from

11. Industry or business Capital Transit Co.

FATHER 12. Name It is Zachariah Greer

13. Birthplace Maryland

MOTHER 14. Maiden name Mary Emily Watson

15. Birthplace Maryland

16. Informant Catherine E. Greer

Address Brandywine, Md.

17. Burial Date thereof Sept. 11, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Emanuel Methodist

Location Bethesda, Maryland

18. Funeral director Ritchie Bros.

Address Upper Marlboro, Md.

19. Sept. 9 19 48 F. H. Billingsley  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 8 September 19 48, at 11:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 Sept 48 19 \_\_\_\_\_ to 8 Sept 19 48 and that I last saw him alive on 8 Sept 48 19 \_\_\_\_\_

Immediate cause of death Pulmonary Edema DURATION 3 hrs.

Due to Cardiac decompensation 3 hrs.

Due to Hypertensive ex. Hemorrhage 8 yrs.

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Robert B. Casser M.D. M.D. or other \_\_\_\_\_

Address Upper Marlboro, Md. Date signed 8 Sept 48

RECEIVED  
SEP 11 1948  
BUREAU V. S.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

096113

23/1245

### 1. PLACE OF DEATH:

County Prince George's

City or town Cheverly, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days, 14 hrs, 30 min.

Hospital, institution, or street address where death occurred:

Prince George's General Hospital

How long in hospital or institution? 4 da, 14 hrs, 30 min.

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Prince Georges

City or town Oxen Hill  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5800 St. Barnabas Rd  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Estelle Grimes

### 3. (b) Social Security Number

4. Sex Fe 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Charles R Grimes

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 8, 1876

8. AGE: Years 71 Months 9 Days 19 If less than one day hrs. min.

9. Birthplace Md  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Robert Ball

13. Birthplace Md

14. Maiden name Lumma Pyles

15. Birthplace Md

16. Informant Daughter Oxen Hill Md

Address 5800 St Barnabas Road

17. Burial Date thereof Sept 30-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bell's M. & L. Cemetery

Location Camp Springs

18. Funeral director Arthur E. Simmons

Address 2007-Nichols ave SE

19. Sept. 27 1948 Mrs. Joe Severe  
(Date rec'd by registrar) (month) (day) (year) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH September 27, 1948 at 1:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 22, 1948 to September 27, 1948 and that I last saw him alive on September 27, 1948

Immediate cause of death Coronary Thrombosis With Myocardial Infarct DURATION 5 days

Due to Arteriosclerotic Heart Disease 3 Years(?)

Due to

Other conditions Cerebral Thrombosis 3 days

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Confirms Above (Gross Findings)

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Smit-Patchie MD M. D. or other

Address 6906 Patchie Rd SE Date signed 9/27/48

Wash DC

PLEASE WRITE PLAINLY in special UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly.

RECEIVED

OCT 1 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09604

Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County: Prince George  
 City or town: Cherry Md  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Prince Georges hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: a.d.  
 City or town: Churchton Md  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. ....  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

John William Gunn

## 3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

susan Gunn

7. Birth date of deceased (mo., day, yr.)

sept 21, 1894

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

5-3

..... hrs. .... min.

9. Birthplace

Canada  
(Town, county, and state)

10. Usual occupation

Plumber

11. Industry or business

John B - Gunn

12. Name

13. Birthplace

Canada

14. Maiden name

Agnes Mickusky

15. Birthplace

scotland

16. Informant

Mrs susan Gunn

Address

Churchton Md

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

sept 21, 1948  
(month) (day) (year)

Cemetery or crematory

Arlington Cemetery

Location

Arlington Va

18. Funeral director

F. Susch's sons

Address

Hyattsville Md

19. (Date rec'd by registrar)

19. 48

Amanda K. Brown

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 18 1948 at 11:40 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... 10..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death: Diffuse bilateralatelectasis ofDue to: Acute tracheitis and obstructivebronchitis

Due to: .....

Other conditions: Cardio-vascular renaldisease - Cerebral edema & congestion

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

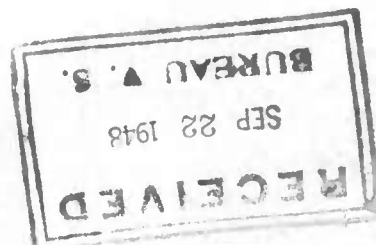
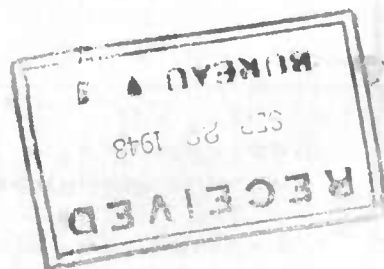
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE: John D. Maloney Dep. Md.Cherry Hyattsville M. D. or otherAddress: Cherry Hyattsville Date signed: 9/14/48





Evidence for change of  
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Reg. No. G 117 SEP 30 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Pro Geo.  
City or town Hyattsville Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Henry Everett Haliday

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Emily F. Haliday

7. Birth date of  
deceased (mo., day, yr.)

Nov 26 - 1861

6. (c) If alive, give age..... years

8. AGE:

86

Years

Months

Days

If less than one day

hrs

min.

9. Birthplace

Washington D.C.

10. Usual occupation

Retired Printer

11. Industry or business

Post Office

FATHER

12. Name

Henry Haliday

13. Birthplace

Washington D.C.

MOTHER

14. Maiden name

unknown

15. Birthplace

Washington D.C.

16. Informant

Charles Richard Brown

Address

Hyattsville Md.

17. (Burial, cremation, or removal. Which?)

Burial

Cemetery or crematory

St. Lincoln

Location

Colma Manor Md.

18. Funeral director

E. Gasche sonja

Address

Hyattsville Md.

19. (Date rec'd by registrar)

Sept 16 1948

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Pro Geo.

City or town 4709 Edmonston Ave

(If outside city or town limits, write RURAL and give nearest town)

Street No. Hyattsville Md.

(If rural, give LOCATION)

2. (a) If veteran, name war Spanish American

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13, 1948 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 10, 1948 to Sept 15, 1948 and that I last saw him alive on Sept 15, 1948

Immediate cause of death

Cerebral Aneurysm

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Dr. W. D. W. D.

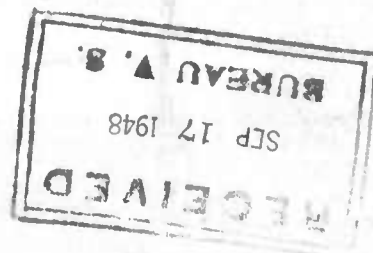
Address Hyattsville, Md. Date signed 9-15-48

MARGIN RESERVED FOR BINDING

9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09606

Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County Prince George'sCity or town Cheverly Md  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 21 hours

Hospital, institution, or street address where death occurred:

Prince George's General HospitalHow long in hospital or institution? 21 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Prince George'sCity or town Hyattsville, Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 5635 Annapolis Rd.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

John Hall

## 3. (b) Social Security Number

4. Sex

M

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Anna L Hall7. Birth date of deceased (mo., day, yr.) Nov. 5, 1865

8. AGE: Years Months Days If less than one day

821025hrs.min.9. Birthplace Little Falls, New York  
(Town, county, and state)10. Usual occupation Retired

11. Industry or business

12. Name unk13. Birthplace New York14. Maiden name unk15. Birthplace New York16. Informant Hosp. RecordsAddress Cheverly Md.17. Burial Date thereof Oct 2, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Consolidated CemeteryLocation Washington D.C.18. Funeral director F. Basch's SonsAddress Hyattsville, Md.19. Oct 7, 48 Amenda Vorony  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 9/30/ 48 19 at 9:05 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9-29-48 19, to 9-30 19 48and that I last saw him alive on 9-30-48 19

Immediate cause of death

Broncho-PneumoniaDue to infection Pulmonary tuberculosis

Due to

Other conditions urinary & hepatic lesions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Broncho-Pneumonia with ur & hepatic lesions

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury Injured at work?

23. SIGNATURE Louis M. Jemel M.D.

M. D. or other

Address Costa Mesa City, Ind. Date signed 9-30-48

RECEIVED

OCT 4 1948

BUREAU V. S.

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 230

1. PLACE OF DEATH: Prince Georges  
 County BERWYN  
 City or town BERWYN  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 yr  
 Hospital, institution, or street address where death occurred:  
5008 Fox St.  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State MARYLAND County Prince Georges  
 City or town BERWYN  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 5008 - Fox  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

3. (a) FULL NAME THERESA VIRGINIA HARBISON

3. (b) Social Security Number

4. Sex FEMALE 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 8. (b) Name of husband or wife Leo HARBISON  
 7. Birth date of deceased (mo., day, yr.) 23 Oct. 1882 6. (c) If alive, give age 55 years

8. AGE: 65 Years 10 Months 28 Days If less than one day  
 hrs. min.

9. Birthplace WASHINGTON, DC  
 (Town, county, and state)  
Housewife

10. Usual occupation None

11. Industry or business

12. Name JOHN Wilson King

13. Birthplace WASH DC

14. Maiden name MARY CHANEY

15. Birthplace WASH DC

16. Informant Leo HARBISON

Address BERWYN

17. Burial Date thereof Sept. 23, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Saint John's Cemetery

Location Forest Glen, Maryland.

18. Funeral director Walter J. Walters

Address 254 Carroll St. Takoma Park, D.C.

19. September 21<sup>st</sup> 1948  
 (Date rec'd by registrar)

Registrar John D. Smith

## MEDICAL CERTIFICATION

20. DATE OF DEATH 21 September 1948 at 4 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6 Sept 48 to 21 Sept 48

and that I last saw him ER alive on 20 Sept 48

Immediate cause of death CHRONIC

Pyelo Nephritis with

UREMIA

Due to CHRONIC ulcer - back

Due to secondary to decubitus

ulcer

Other conditions Fracture left

Hip, old

(Include pregnancy within 3 months of death)

Major findings of operations JUNE 1948 Fracture,

neck left FEMUR Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of June 1948

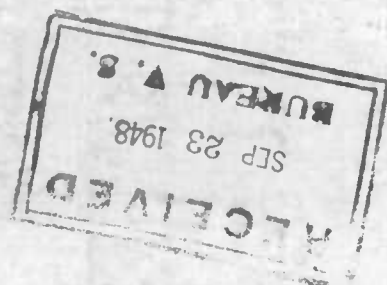
Where did injury occur? Berwyn (City or town) Ind. (County) Ind. (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Fall Injured at work?

23. SIGNATURE Chenine M. D. Chenine

Address Berwyn, Ind. Date signed 9/21/48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County... Prince GeorgesCity or town... Riverdale  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 days

Hospital, institution, or street address where death occurred:

Selands Memorial HospitalHow long in hospital or institution? 6 days

## 3. (a) FULL NAME

David Robert Jackson

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

8. (b) Name of husband or wife

8. (c) If alive, give age... years

7. Birth date of

deceased (mo., day, yr.)

Nov. 13, 1928

8. AGE:

Years

Months

Days

If less than one day

191011

hrs.

min.

9. Birthplace...

Charlotte, N. Carolina  
(Town, county, and state)

10. Usual occupation

Book-keeper

11. Industry or business

FATHER

12. Name

Paul Adams Jackson

13. Birthplace

York County, S. Carolina

14. Maiden name

Norma Hobbs

15. Birthplace

Sumner, N. Carolina

16. Informant

Hospital Records

Address

Riverdale, Md.

17.

(Burial, cremation, or removal, Which?)

Burial

Date thereof

9-27-48  
(month) (day) (year)

Cemetery or crematory

Fort Lincoln Cemetery

Location

Calver Manor road

18. Funeral director

W. W. Chambers &

Address

Riverdale, Md.

19.

(Date rec'd by registrar)

Sept 28

18.

48James Perry

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State

Maryland P. George

City or town

Riverdale  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

5223-42nd Place

(If rural, give LOCATION)

2. (a) If veteran, name war

none

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 24

19

48 at 9-22A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19

to

19

and that I last saw h

alive on

19

Immediate cause of death

Cerebral concussion

DURATION

Due to

Due to

Other conditions

Multiply fractured ribs  
with multiple lacerations - 3 or 4 -  
(Include pregnancy within 3 months of death)

Major findings of operations

Ruptured bladder - hemorrhage shock

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Accident

Date of

Sept 13, 1948

Where did injury occur?

Bowie-Sancti Rd. P. Geo. Md.  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Public Highway

Means of injury

Auto turned over

Injured at work?

23. SIGNATURE

John W. Maloney, Examiner

M. D. or other

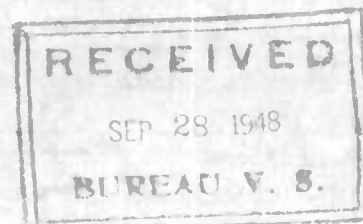
Address

Chesley - Hyattsville Md.

Date signed

9-24-48





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 252

## 1. PLACE OF DEATH:

County Prince GeorgesCity or town Chapel Oaks  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Chapel Oaks  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1116-57" Ave.  
(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Minnie Jackson

## 3. (b) Social Security Number

4. Sex Female5. Color or race Negro6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Edward Jackson7. Birth date of deceased (mo., day, yr.) June 10, 18848. AGE: Years 64 Months 3 Days 4 If less than one day  
hrs. min.9. Birthplace Hatton Pond, Va.  
(Town, county, and state)10. Usual occupation none

11. Industry or business

12. Name Brack Sellers13. Birthplace Va.14. Maiden name Minnie Sellers15. Birthplace Hatton Pond, Va.16. Informant John E. JacksonAddress 1116-57" Ave.17. Removal Date thereof 9-14-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory 1Location Washington D.C.18. Funeral director Malcolm SellersAddress 424-R St. N.W.19. Sept 14 19 48 Carrie Canphree  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 14, 1948 at 12:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1946 to Sept. 14, 1948 and that I last saw him alive on Sept. 13, 1948Immediate cause of death Congestive Heart Failure

DURATION

Due to Hypertensive Cardio-Vascular Disease - 3°

Due to

Other conditions Polyarthrititis, Acute Gastroenteritis & Nausea & Vomiting  
(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE John W. Robinson, M.D. M. D. or otherAddress 1001 Eastern Ave. N.E. Date signed 9/14/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
SEP 16 1948  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

09610

## CERTIFICATE OF DEATH

Reg. Dist. No.

2260

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

4911-Sackawanna St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Pr. Geo.City or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4911 Sackawanna St.  
(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

Jennie Elizabeth Junghans

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

W.

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

George Ralph Junghans

7. Birth date of

deceased (mo., day, yr.)

May 3, 1893

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

35422

hrs.

min.

9. Birthplace

Washington, D.C.  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

12. Name Charles Bernhardt13. Birthplace Wash., D.C.14. Maiden name Alice Conway15. Birthplace Washington, D.C.16. Informant George R. JunghansAddress 4911-Sackawanna St.17. BURIAL(Burial, cremation, or removal, which?) Date thereof Sept 30, 1948  
(month) (day) (year)Cemetery or crematory Ft. LincolnLocation Edison Grave Yard18. Funeral director Jos. Fowler's SonAddress 1756 Q Ave N.W.19. Sept 29 1948

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1948 at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 19 to 19

Immediate cause of death

Carcinoma of breast with metastasis (general)

DURATION

5 years

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John D. Maloney Deputy Med. ExaminerAddress Chesley-Hyaltonville, Md. Date signed 9-27-48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

### 1. PLACE OF DEATH:

County Prince Georges  
City or town High Bridge Md  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md County Prs Georges  
City or town Bowie  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Julius Kramer

### 3. (b) Social Security Number

#### 4. Sex

male

#### 5. Color or race

white

#### 6. (a) Single, married, widowed, or divorced

single

#### 6. (b) Name of husband or wife

#### 7. Birth date of deceased (mo., day, yr.)

June 3, 1889

#### 6. (c) If alive, give age years

#### 8. AGE:

Years 59 Months 1 Days 1 If less than one day  
hrs. min.

#### 9. Birthplace

Wisconsin  
(Town, county, and state)

#### 10. Usual occupation

Painter

#### 11. Industry or business

Conrad Kramer

#### 12. Name

Germany

#### 13. Birthplace

Lydia Klenback

#### 14. Maiden name

Germany

#### 15. Birthplace

Otto Kramer

#### 16. Informant

Bowie Md.

#### Address

Burial Date thereof Sept 20, 1948

#### (Burial, cremation, or removal, Which?)

Cullington National

#### Cemetery or crematory

Washington Va

#### Location

F. Gaseck's sons

#### 18. Funeral director

Hyattsville Md.

#### Address

Sept 20, 1948 Amanda Coroney

#### (Date read by registrar)

#### Registrar

### MEDICAL CERTIFICATION

#### 20. DATE OF DEATH

Sept 15, 1948 at 11:20 P.M.

#### 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to ..... 19.....

and that I last saw him ..... alive on ..... 19.....

Immediate cause of death multiple

compression of - compressed

fractures of head & face

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of Sept 15, 1948

Where did injury occur? Bowie P. Co. Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public Highway

Means of injury Auto Injured at work?

23. SIGNATURE John J. Maloney Dep. Med.

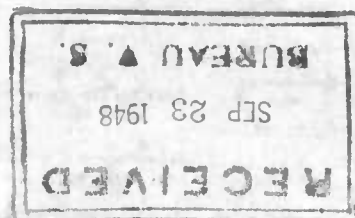
Examiner M. D. or other

Address Hyattsville Date signed 9-16-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09612

Reg. Dist. No.

232

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Upper Marlboro, Rt. 2  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 14 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Prince Georges  
 City or town Rt. 2, Upper Marlboro  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war No

## 3. (a) FULL NAME

JOHN HENRY LEWIS

## 3. (b) Social Security Number

No

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Agnes C. Lewis  
 (nee Quade) 8. (c) If alive, give age 58 years  
 7. Birth date of deceased (mo., day, yr.) March 9, 1870  
 8. AGE: Years 78 Months 6 Days 21 If less than one day  
 .....hrs. ....min.

9. Birthplace Fairfax Co., Virginia  
 (Town, county, and state)  
 10. Usual occupation Farmer  
 11. Industry or business  
 FATHER 12. Name John B. Lewis  
 13. Birthplace Virginia  
 MOTHER 14. Maiden name Lucy Ellen Harris  
 15. Birthplace Virginia

18. Informant Mrs. Agnes C. Lewis  
 Address Rt. 2, Upper Marlboro, Md.  
 17. Burial Date thereof Oct. 4, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Mt. Carmel  
 Location Upper Marlboro, Maryland

18. Funeral director Richie Bros  
 Address Upper Marlboro, Maryland  
 19. Oct 1<sup>st</sup> 48 19 48  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Thursday, Sept 30, 1948, 8:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Feb 15, 1948, to Sept 30, 1948  
 and that I last saw him alive on Sept 29, 1948

Immediate cause of death Coronary Heart Failure  
 Due to Arteriosclerosis  
 Due to Nephritis  
 Other conditions Alber Right Leg (varicose)  
 (Include pregnancy within 3 months of death)

## DURATION

1 year  
10 yrs  
5 yrs  
6 yrs

Major findings of operations none  
 Date of op. \_\_\_\_\_  
 Autopsy results NO  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE James E. Sasser M. D. or other  
 Address Upper Marlboro Date signed 10-1-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly



**RECEIVED**

OCT 4 1948

**BUREAU V. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09613

Reg. Dist. No. *mf5*

## 1. PLACE OF DEATH:

County *Prince & Geo.*City or town *MT. RAINIER*  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *7 YRS.*

Hospital, institution, or street address where death occurred:

*4207 34th Street*How long in hospital or institution? *—*

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *md*, County *Prince Geo.*City or town *MT Rainer*  
(If outside city or town limits, write RURAL and give nearest town)Street No. *4207-34th St.*  
(If rural, give LOCATION)2.(a) If veteran, name war *—*

## 3. (a) FULL NAME

*PAULINE E. LITTLE*

## 3. (b) Social Security Number

## 4. Sex

*FEMALE*

## 5. Color or race

*WHITE*

## 6. (a) Single, married, widowed, or divorced

*MARRIED*

## 6. (b) Name of husband or wife

*FLOYD - J.**Feb - 27 - 1910*6. (c) If alive, give age *56* years7. Birth date of deceased (mo., day, yr.) *↑*

## 8. AGE:

Years

Months

Days

If less than one day

*48*

hrs.

min.

## 9. Birthplace:

*Spartanburg South Carolina*  
(Town, county, and state)

## 10. Usual occupation:

*Housewife*

## 11. Industry or business

*none*

## FATHER

## 12. Name

*T. R. Anderson*

## 13. Birthplace

*South Carolina*

## MOTHER

## 14. Maiden name

*Nora Mc Mahin*

## 15. Birthplace

*South Carolina*

## 16. Informant:

*Floyd J. Little*

## Address

*4207-34th St. Mt. Rainer*

## 17. (Burial, cremation, or removal, Which?)

*Burial*

## Date thereof

*9-7-48*  
(month) (day) (year)

## Cemetery or crematory

*Elmwood Custy*

## Location

*Charlotte, N.C.*

## 18. Funeral director:

*W. W. Hancock & Co.*

## Address

*Princeton, Md*19. *Sept 7**1948**James Severy**Registrar**Sept 7, 48*

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept. 7* 19*48* at *12:45* M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Aug 1* 19*48* to *Sept 7* 19*48*and that I last saw her alive on *Sept 6* 19*48*Immediate cause of death *Carcinoma of cervix with*

## DURATION

*6 mos.*Due to *generalized metastasis*Due to *—*Other conditions *—*

(Include pregnancy within 3 months of death)

Major findings of operations *malignant Carcinoma of cervix*Date of op. *Aug 23, 48*Autopsy results *—*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *—* Date of *—*Where did injury occur? *—* (City or town) (County) (State)Injured at home, farm, industry, public place (where?) *—*Means of injury *—* Injured at work? *—*23. SIGNATURE *Samuel J. N. Sugar MD*Address *Mt. Rainer, Md* Date signed *Sept 7, 48*

RECEIVED

SEP 8 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. **Correct age** is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09614

Reg. Dist. No. 248

## 1. PLACE OF DEATH:

County... Priscilla, GeorgiaCity or town... Priscilla  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Leeland Mem. Hosp.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... New York County...City or town... Dickinson Heights  
(If outside city or town limits, write RURAL and give nearest town)Street No. 3756-85th Street  
(If rural, give LOCATION)

2.(a) If veteran, name war...

## 3. (a) FULL NAME

Robert - E. Maginnis

## 3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married6.(b) Name of husband or wife... Helen Maginnis

7. Birth date of deceased (mo., day, yr.)

October 12, 1898

6.(c) If alive, give age... years

8. AGE:

561025

If less than one day

hrs. min.

9. Birthplace

Waukegan, Illinois  
(Town, county, and state)

10. Usual occupation

Secretary

11. Industry or business

American District Telegraph Corp

MOTHER

FATHER

12. Name

Edward Maginnis

13. Birthplace

Ireland

14. Maiden name

Hellie Dolan

15. Birthplace

Wisconsin

16. Informant

Mrs. Helen Maginnis

Address

3756-85th St., Jackson Heights, N.Y.

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof

Sept 9, 1948  
(month) (day) (year)

Cemetery or crematory

Nysson Funeral Home

Location

1376 4th St. 2nd fl.

18. Funeral director

Address

7 Gascht sons

19. Sept 9

1948

(Date rec'd by registrar)

James Servey

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... Sept 9 1948 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... 10... 19...

and that I last saw him... alive on... 19...

Immediate cause of death

DURATION

Coronary Occlusion sudden

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John J. Maloney, M.D.

M. D. or other

Address... Cherry Hill, Hyattsville Date signed... 9-9-48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

## 1. PLACE OF DEATH:

County..... Prince Georges  
 City or town..... Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 yr., 4 mos., 21 days  
 Hospital, institution, or street address where death occurred:  
 Glenn Dale Sanatorium  
 How long in hospital or institution? 1 yr., 4 mos., 21 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D. C. County.....  
 City or town..... Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 217 E. St., N. W.  
 (If rural, give LOCATION)

2.(a) If veteran, name-war

## 3. (a) FULL NAME

Mc NEELY, WILLIAM

## 3. (b) Social Security Number

--

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or wife Hannah Thompson  
 7. Birth date of deceased (mo., day, yr.) October 18, 1859  
 8. AGE: Years 88 Months 88 Days 10 If less than one day 19 hrs. min.

9. Birthplace Pittsburgh, Pennsylvania  
 (town, county, and state)  
 10. Usual occupation Rolling Mill Employee  
 11. Industry or business  
 12. Name James G. McNeely  
 13. Birthplace Pittsburgh, Pennsylvania  
 14. Maiden name Lavana Gardner  
 15. Birthplace West Liberty, Pennsylvania

16. Informant Deceased  
 Address  
 17. Burial, cremation, or removal, Which? Date thereof 9 7 48  
 (month) (day) (year)  
 Cemetery or crematory  
 Location  
 18. Funeral director W-W Chambers Co.  
 Address 517-11th St. S.E.  
 19. Sept 7, 1948 Rowland S. Philips  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 6, 1948 at 3:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15, 1947 to September 6, 1948  
 and that I last saw him alive on September 6, 1948

Immediate cause of death Coronary Thrombosis  
 DURATION 1 day

Due to  
 Due to

Other conditions Pulmonary Tuberculosis 2 yrs  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Daniel Leo Fincone MD  
 M. D. or other  
 Address Glen Dale Md Date signed 8/26/48

MARGIN RESERVED FOR BINDING

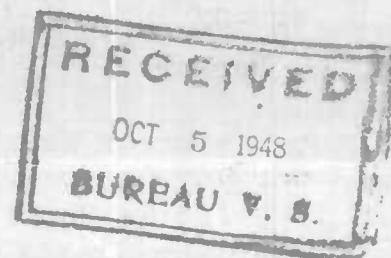
VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.









# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09617

Reg. Dist. No. 245

### 1. PLACE OF DEATH:

County Prince Georges

City or town (Rural) Hyattsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Mother Jones Rest Home

How long in hospital or institution? 13 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County

City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1745 Park Road, N.W.  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3.(a) FULL NAME

MARY MITCHELL

### 3.(b) Social Security Number

4. Sex F 5. Color or race W 6.(b) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife John Mitchell  
Feb. 14, 1851 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 14, 1851

8. AGE: Years 97 Months 7 Days If less than one day  
hrs. min.

9. Birthplace Kentucky  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

12. Name Unknown

13. Birthplace Ky.

14. Maiden name ? Price

15. Birthplace Ky.

16. Informant Mr. Frank Mitchell

Address 1745 Park Rd., N.W. D.C.

17. Burial Date thereof Sept. 15/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Glenwood Cemetery

Location Washington, D. C.

18. Funeral director S. A. Jones Co.

Address 2901-14th St., N.W. D.C.

19. Sept. 14" 48 Mrs. J. S. Severa  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH September 13 1948 at 6:25 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 19 47 to Sept 13 19 48  
and that I last saw her alive on August 27 19 48

Immediate cause of death Cerebral Hemorrhage DURATION 14 days

Due to Arteriosclerosis

Due to

Other conditions senility

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: none

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James M. Lottus

Address 1673 Park Road - Wash. D.C. M. D. or other

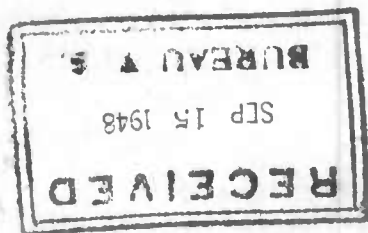
Date signed Sept 13 1948

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH LEADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. John L. <sup>Elkerson, Md</sup> Maloney (Coroner)  
notified and will approve -  
James W. Loftus M.D.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

2131

## 1. PLACE OF DEATH:

County Prince George's General HospitalCity or town Cheverly, Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 days

Hospital, institution, or street address where death occurred:

Prince George's General HospitalHow long in hospital or institution? 10 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Cottage City Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 408 Parkwood Street  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

Amalie Munk

## 3.(b) Social Security Number

4. Sex

Fe

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Widow

6.(b) Name of husband or wife

Louis Munk

7. Birth date of deceased (mo., day, yr.)

June 20, 1871

6.(c) If alive, give age years

8. AGE:

77

Years

Months

3

Days

8

If less than one day

hrs.min.

9. Birthplace

Germany

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

Theodore Israel

13. Birthplace

Germany

14. Maiden name

Johanna Rosenthal

15. Birthplace

Germany

16. Informant

Thekla Lawson

Address

3723-42 av Cottage City Md

17. (burial, cremation, or removal. Which?)

Cremation

Date thereof

Sept 29, 1948  
(month) (day) (year)

Cemetery or crematory

Fort Lincoln

Location

Colinas Manor Md

18. Funeral director

F. Suscha sonny

Address

Hyattsville Md

19.

Sept 29, 1948  
(Date read by registrar)Amanda Dorsey  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28, 19 48 at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Sept 17 19 48 to Sept 28 19 48and that I last saw her alive on Sept 28 19 48

Immediate cause of death

Ischemic myocardial infarction

DURATION

sudden

Disease

Long standing Myocardial infarction complicated by pulmonary edema

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Pulvic abscessDate of op. 9-20-48

Autopsy results

Same

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John D. Maloney, M.D.

M. D. or other

Address Chesley HyattsvilleDate signed 9-29-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 1 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

09619

239

## 1. PLACE OF DEATH:

County PRINCE GEORGECity or town LAUREL  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

Warren's Hospital, LAUREL, MdHow long in hospital or institution? 1 day

## 3. (a) FULL NAME

MURPHY, Frank

## 3. (b) Social Security Number

4. Sex

M

5. Color or race

W

8. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

December 26, 1874

8. AGE:

Years

Months

Days

If less than one day

7393

hrs.

min.

9. Birthplace

Quincy, Indiana  
(City, county, and state)

10. Usual occupation

Retired: R.R. employee

11. Industry or business

FATHER

12. Name

William Murphy

13. Birthplace

Ky.

MOTHER

14. Maiden name

Esther Ellen

15. Birthplace

Ky.

16. Informant

Miss Ethel Murphy

Address

FAIRLAND, Md.17. Burial  
(Burial, cremation, or removal. Which?)

Date thereof

Oct. 4, 1948  
(month) (day) (year)

Cemetery or crematory

Crown Hill Cemetery

Location

Indianapolis, Indiana

18. Funeral director

Arthur Walters

Address

505 Washington Blvd. Laurel, Md

19.

(Date rec'd by registrar)

19

48M. Brashers

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Montgomery

City or town

Fairland, Md.  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

Rt. 2, Silver Spring, Md.  
(If rural, give LOCATION)

2. (a) If veteran, name war

WWII

## MEDICAL CERTIFICATION

20. DATE OF DEATH

September 30

19

48

at

5:07 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 19, 48 to Sept 20, 48and that I last saw him alive on September 29, 1948

Immediate cause of death

Uremia

DURATION

3 d.

Due to

Arteriosclerosis3 y

Due to

Chronic myocarditis3 mo.

Other conditions

Chronic myocarditis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

B. P. Warren, M.D.  
By Wm. B. Brashers, M.D.

M. D. or other

Address

Laurel, Md

Date signed

9/30/48

**RECEIVED**

OCT 4 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 09620 239

## 1. PLACE OF DEATH:

County..... Prince George's  
 City or town..... Laurel, Maryland  
 How long in above place of death? June 19, 1948  
 Hospital, institution, or street address where death occurred:  
Laurel Sanitarium, Laurel, Md.  
 How long in hospital or institution? 3 mos., 3 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D. C. County.....  
 City or town..... Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1751 P St., N. W.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war..... ☒

## 3. (a) FULL NAME

Catherine A. Myers

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married6. (b) Name of husband or wife xxx C. J. Myers7. Birth date of deceased (mo., day, yr.) July 12, 1866 6. (c) If alive, give age years8. AGE: Years Months Days If less than one day  
82 2 12 8 hrs. min.9. Birthplace D. C.  
(Town, county, and state)10. Usual occupation Retired Gov't Service

## 11. Industry or business

12. Name John A. Sailer13. Birthplace D. C.14. Maiden name Lena Summers15. Birthplace D. C.16. Informant Son, H. C. McGrawAddress Takoma Park, Md.17. Burial Date thereof Sept 28 - 48  
(Burial, cremation, or removal to other place) (month) (day) (year)Cemetery or crematory St. Charles  
Washington D.C.Location The S.H. Bines Co18. Funeral director The S.H. Bines CoAddress 2901 14TH St. N.W. Washington, D.C.19. Sept 25 - 48 M. Brashers  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 25 19 48, at 12:47 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19, 1948 to Sept 25 19 48  
and that I last saw him/her alive on 9/24 at 10 P.M. 19 48  
Immediate cause of death ChronicNephritisDURATION  
Indef.

Due to.....

Due to.....

Other conditions Arterio-Sclerosis 1 yr

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Jesse A. Bryson M. D. or otherAddress Laurel Md Date signed Sept 25 - 48

RECEIVED

SEP 28 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No.

09621

234

## 1. PLACE OF DEATH:

County Prince Georges

City or town Accokeek  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Accokeek  
(If outside city or town limits, write RURAL and give nearest town)Street No.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Jane Minnie Newman

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

Colored

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Robert O'Connell Newman

6. (c) If alive, give age 34 years

## 7. Birth date of deceased (mo., day, yr.)

Sept 20, 1912

## 8. AGE:

Years 36 Months Days If less than one day

## 9. Birthplace

Maryland (Town, County, and State)

## 10. Usual occupation

Housewife

## 11. Industry or business

Maryland

## FATHER

12. Name Richard Washington

## MOTHER

13. Birthplace Maryland

## 14. Maiden name

Cory Amiger

## 15. Birthplace

Maryland

16. Informant Robert O'Connell Newman

Address Accokeek, Md.

17. Burial, cremation, or removal, Which? Date thereof Oct 2, 1948

Cemetery or crematory Macedonia Baptist Church

Location Charles Co. Md.

18. Funeral director Barnet Matthews

Address 614-4 St. S.W. Wash. D.C.

19. Date rec'd By registrar Sept 27 1948

20. Signature Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1948 at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

## Immediate cause of death

Hemorrhage and shock

Due to Gun shot wound

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur Accokeek (City or town) Prince Georges (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Shot with shot gun

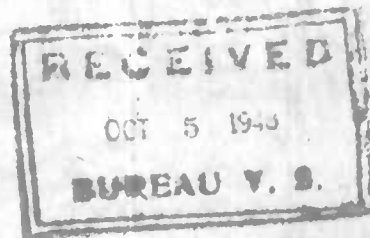
Injured at work? No

23. SIGNATURE Deputy Medical Examiner

Address Fredrickson Date signed 9-26-48

Mrs Davis

Riddlebarger



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09622

Reg. Dist. No. 242

## 1. PLACE OF DEATH:

County Prince George  
 City or town Bowie  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Death occurred at home

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Bowie  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Marie O'Neal

## 3. (b) Social Security Number

4. Sex Female 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Preston O'Neal

7. Birth date of deceased (mo., day, yr.) 1881 8. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 67 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace unknown  
 (Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Calvin Flavenham

13. Birthplace Geo

14. Maiden name unknown

15. Birthplace unknown

16. Informant Edna Hall

Address Bowie M.D.

17. Burial Date thereof Sept. 19, 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Harmony

Location Washington D.C.

19. Funeral director John T. Stewart

Address 30 H. St. N.E.

Sept. 19, 1948 Registrar Carrie F. Campbell

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19, 1948 at 1:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 11, 1948 to Sept. 19, 1948

and that I last saw her alive on Sept. 19, 1948

Immediate cause of death Uremia

DURATION 10 days

Due to Cardiovascular - Renal Disease

Due to Hypertension + Arteriosclerosis

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(City or town) (County) (State)

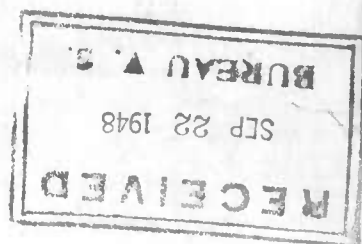
Injured at home, farm, industry, pub'c place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE T. Richard Conner, M.D.

Address Bowie, Md. Date signed 9-19-48

(M. D. or other)





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

09623  
242  
231

### 1. PLACE OF DEATH:

County **Prince Georges**  
City or town **Suitland**  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death **Permanent**  
Hospital, institution, or street address where death occurred:  
**4215 - Spring Street**  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State **District of Columbia**  
County  
City or town **Washington D. C.**  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. **713 1/2 Smith Road N. W.**  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

**Pearl Beatrice Parker**

### 3. (b) Social Security Number

4. Sex **female**  
5. Color or race **colored**  
6. (a) Single, married, widowed, or divorced **single**  
6. (b) Name of husband or wife  
6. (c) If alive, give age years  
7. Birth date of deceased (mo., day, yr.) **Nov 11, 1908**  
8. AGE: Years **39** Months Days If less than one day hrs. min.

### MEDICAL CERTIFICATION

20. DATE OF DEATH **Sept 8 1948** at **7:55 P**  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
and that I last saw him alive on  
Immediate cause of death **acute congestive heart failure**  
Due to **cardiovascular renal disease**  
Other conditions  
(Include pregnancy within 3 months of death)  
Major findings of operations  
Date of op.  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

9. Birthplace **Washington D. C.**  
(Town, county, and state)  
10. Usual occupation **general housework**  
11. Industry or business  
12. Name **Frank Parker**  
13. Birthplace **Maryland**  
14. Maiden name **Clara M. Anderson**  
15. Birthplace **Maryland**

16. Informant **Daisy Parker**  
Address **38 Q St N W Apt 1 Washington D. C.**

17. **Removal** Date thereof **9 Sept 1948**  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory **Stewart's Memorial Home**  
Location **Washington D. C.**

18. Funeral director **E. B. Borch's Sons**  
Address **Huntville, Md.**

19. **9/19** 19 **48** **Emmanuel H. Gorman**  
(To be rec'd by registrar) Registrar **Carrie Campbell**

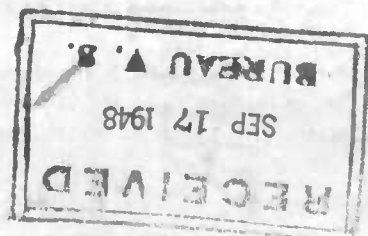
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?  
23. SIGNATURE **Emmanuel H. Gorman** M. D. or other  
Address **Forestville, Md.** Date signed **9-9-48**

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of length of residence shown on Film  
G124 3/16/50 dm.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 244

## 1. PLACE OF DEATH:

County Pr. Geo.  
City or town Capital Heights Md  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 1/2 years  
Hospital, institution, or street address where death occurred:  
417-59 Ave  
How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Pr. Geo.  
City or town Capital Heights  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 417-59 Ave  
(If rural, give LOCATION)  
2(a) If veteran, name war

## 3. (a) FULL NAME

Anderson Woods Parks

## 3. (b) Social Security Number

4. Sex Male 5. Color or race w. 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Annabel M. Parks  
7. Birth date of deceased (mo., day, year) Aug. 14 1872 6. (c) If alive, give age \_\_\_\_\_ years  
8. AGE: Years 76 Months \_\_\_\_\_ Days \_\_\_\_\_ It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Mo (Town, county, and state)  
10. Usual occupation Retired Gov.

## 11. Industry or business

FATHER 12. Name William J. Parks  
13. Birthplace Mo  
MOTHER 14. Maiden name Elizabeth Anthony  
15. Birthplace Mo

16. Informant Annabel M. Parks  
Address 417-59 Ave

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Sept 27-48 (month) (day) (year)  
Cemetery or crematory Cedar Hill  
Location Suitland Maryland

18. Funeral director Deal Funeral Home  
Address 4812- La Ave. NW

19. Sept 24 19 48 Carrie F. Campbell  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 23 19 48, at 11:25 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 13 19 48, to September 23 19 48, and that I last saw him alive on September 18 19 48.

Immediate cause of death Myocardial heart disease  
DURATION

Due to

Due to

Other conditions Carcinoma of urinary bladder

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

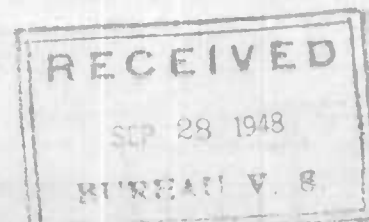
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ernest C. Cammensen MD  
M. D. or other

Address 4400 Bowen Rd. SE Date signed 9/23/1948



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09625

## CERTIFICATE OF DEATH

Reg. Dist. No. 230

### 1. PLACE OF DEATH:

County Prince George  
City or town Berwyn  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 1/2 years  
Hospital, institution, or street address where death occurred:  
9929- Wash. Balt. Boulevard.  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Prince George  
City or town Berwyn  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 9929- Wash. Balt. Boulevard.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

George Avery Phillips

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
6.(b) Name of husband or wife Hamnie S Phillips  
7. Birth date of deceased (mo., day, yr.) July 5, 1916, 6.(c) If alive, give age 63 years

8. AGE: Years 62 Months 2 Days 23 hrs. min.  
9. Birthplace Ashland, Alabama  
(Town, county, and state)  
10. Usual occupation Caretaker at Golf Club.

11. Industry or business

12. Name Francis Marvin Phillips  
13. Birthplace Herd County, Ga.  
14. Maiden name Sarah Cottrill  
15. Birthplace Herd County, Ga.

16. Informant Hamnie Phillips  
Address 9929- Wash. Balt. Boulevard,  
transportation Date thereof Sept 29, 1948  
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Alexander City  
Alabama  
Location F. Pasche, sons  
Hyattsville Md.

18. Funeral director Amanda Downey  
Address Sept 29 48  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH September 28, 1948, at 10:00 AM  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
.....19....., 10....., 19.....  
and that I last saw h.....alive on.....19.....

Immediate cause of death.....  
Coronary vascular  
renal disease  
Due to.....  
Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings of operations.....  
Date of op.....  
Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE John D. Maloney Sept. med.  
Cherly Hyattsville Examiner  
Address..... M. D. or other  
Date signed 9-28-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
OCT 4 1948  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09626

Reg. Dist. No. 234

## 1. PLACE OF DEATH:

County Prince George  
 City or town Arton Hill  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death Present  
 Hospital, institution, or street address where death occurred  
Indian Head Road  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State District of Columbia  
 City or town Washington D. C.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1102 1/2 2 st D. C.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war ☒

## 3. (a) FULL NAME

Ruth Poston

## 3. (b) Social Security Number

4. Sex female 5. Color or race colored 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Oct 7 1926 8. (c) If alive, give age 19 years

8. AGE: Years 21 Months 0 Days 0 If less than one day 0 hrs. 0 min.

9. Birthplace Greensboro North Carolina  
 (Town, county, and state)

10. Usual occupation General housework11. Industry or business Lonzo Poston12. Name Shelby North Carolina13. Birthplace North Carolina14. Maiden name Delia Wilson15. Birthplace North Carolina16. Informant George WilsonAddress Gum Springs va Route 1 Box 31017. (Burial, cremation, or removal, Which?) Burial Date thereof Oct 8 1948Cemetery or crematory Gum SpringsLocation va18. Funeral director John T. Rhines & CoAddress 901-33rd St. S.W. D.C.19. Date of death 9/24 48 Registrar Amanda Doney20. Date of death 9/24 48 Registrar Amanda Doney21. Date of death 9/24 48 Registrar Amanda Doney22. Date of death 9/24 48 Registrar Amanda Doney23. Date of death 9/24 48 Registrar Amanda Doney24. Date of death 9/24 48 Registrar Amanda Doney25. Date of death 9/24 48 Registrar Amanda Doney

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 1948 at 130 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him 19 to 19Immediate cause of death Hemorrhage and shockDue to Crushed chest

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

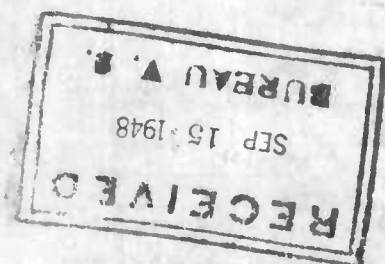
22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 9-4-48Where did injury occur? Front Hill (City or town) Prince George (County) D.C. (State)Injured at home, farm, industry, public place (Where?) Indian Head RoadMeans of injury Crushed chest23. SIGNATURE Dr. J. H. Rhines M. D. or otherAddress 901-33rd St. S.W. D.C. Date signed 9-6-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

0963439  
281

### 1. PLACE OF DEATH:

City or town Prince Georges  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 5 days  
Hospital, institution, or street address where death occurred:  
Prince Georges Hospital  
How long in hospital or institution? 5 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Prince Georges  
City or town Ladysburg  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Rogow, Baby Boy ROBERT JAMES, JR.

### 3. (b) Social Security Number

4. Sex M 5. Color or race W 8.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife \_\_\_\_\_ 6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Sept 8, 1948

8. AGE: Years \_\_\_\_\_ Months 3 Days \_\_\_\_\_ At less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Chesapeake, Md  
(Town, county, and state)

10. Usual occupation Infant

11. Industry or business JAMES

12. Name Robert J. Rogow, Sr.

13. Birthplace Crownsville, Md.

14. Maiden name Mary Anna E. Edemann

15. Birthplace Philadelphia, Pa

16. Informant Mrs C N Hill

Address Crownsville, Md

17. Burial Date thereof Sept 14, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Forest Grove, Pa

Location Near Peach Bottom, Pa

18. Funeral director F. C. Johnson

Address 2 King Lion, Md

19. 9/13 19 48 Amanda H. Dorney  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 19 48 at 3:27 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-8 19 48 to 9-13 19 48

and that I last saw him alive on 9-13 19 48

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Cerebral Hemorrhage

Duo to \_\_\_\_\_

Duo to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Manner of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE A. D. D. W. D.

Address Hagerstown, Md M. D. or other \_\_\_\_\_

Date signed \_\_\_\_\_

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
SEP 15 1948  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

## 1. PLACE OF DEATH:

County... Prince Georges  
 City or town... Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 yrs., 1 mo., 21 days  
 Hospital, institution, or street address where death occurred:  
 Glenn Dale Sanatorium  
 How long in hospital or institution? 2 yrs., 1 mo., 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State... D. C. County...  
 City or town... Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... 2015 - 15th St., N. W.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

HARRY ARTHUR REED

## 3. (b) Social Security Number

577-05-1894

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Mrs. Katherine K. Reed

7. Birth date of deceased (mo., day, yr.) April 30, 1886  
 8. (c) If alive, give age 56 years

8. AGE: Years Months Days If less than one day  
 62 62 4 24 hrs. min.

9. Birthplace Olney, Illinois  
 (Town, county, and state)

10. Usual occupation Butcher

11. Industry or business - - -

12. Name Charles Reed

13. Birthplace Olney, Illinois

14. Maiden name Lydia Coughton

15. Birthplace Olney, Illinois

16. Informant Deceased

Address

17. Renewal to burial (Burial, cremation, or removal. Which?) Date thereof Sept 24 1948  
 (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director S. H. Phillips Co.

Address 2901 14th St N.W.

19. Sept 24, 1948 Rowland S. Phillips  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23, 1948, at 7:57 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 1, 1946, to Sept. 23, 1948, and that I last saw him alive on Sept. 23, 1948.

Immediate cause of death Pulmonary Tuberculosis  
 DURATION 2 yrs 2 mo

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel H. Pincus M.D.  
 M. D. or other  
 Address Glenn Dale, Md. Date signed 9/23/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 4 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

09629

234

## 1. PLACE OF DEATH:

County Prince GeorgesCity or town Groton Hill  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death Permanent

Hospital, institution, or street address where death occurred:

Indian Head Road

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of ColumbiaCity or town 11024 street S. E.  
(If outside city or town limits, write RURAL and give nearest town)Street No. Washington D. C.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

John Rivers

## 3. (b) Social Security Number

4. Sex

male

5. Color or race

colored

6.(a) Single, married, widowed, or divorced

divorced

6.(b) Name of husband or wife Birdie Lee Rivers6.(c) If alive, give age 27 years7. Birth date of deceased (mo., day, yr.) March 12, 1916

8. AGE: Years Months Days If less than one day

32

hrs.

min.

9. Birthplace Monroe North Carolina  
(Town, county, and state)10. Usual occupation auto mechanic11. Industry or business own businessFATHER 12. Name walter rivers13. Birthplace Monroe North CarolinaMOTHER 14. Maiden name harriett Crowder15. Birthplace Monroe North Carolina16. Informant ella Corney riversAddress 1535 14th st N W Washington D. C.17. Removal Removal Date thereof Sept 6, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Ford Funeral HomeLocation 1213-4 st S.W Washington DC18. Funeral director F. GaschersonsAddress Hyattsville Md.19. 9/6 19 48 Amanda W. Jones  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 19 48 at 130 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Hemorrhage and shock  
Crushed skull

Due to

Due to

Other conditions

(Include pregnancy within 9 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 9-4-48Where did injury occur? Groton Hill (City or town) Prince Georges (County) Md. (State)Injured at home, farm, industry, public place (where?) Indian Head RoadInjury Motor Cycle Injured by Automobile23. SIGNATURE James D. S. Jones M.D. or otherAddress Forest Hill, Md. Date signed 9-6-48

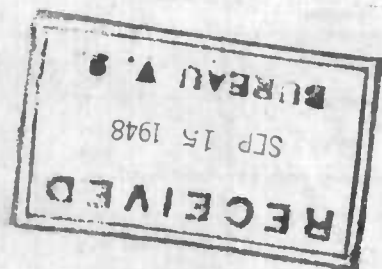
MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Send to Piscataway





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 09634  
245

## 1. PLACE OF DEATH:

County Prince Georges  
City or town 27 Brentwood, Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 years

Hospital, institution, or street address where death occurred:

4520 - 39th Place

How long in hospital or institution?

## 3. (a) FULL NAME

Josephine Rose

4. Sex

F

5. Color or race

C

6. (a) Single, married, widowed, or divorced

Widowed

8. (b) Name of husband or wife

Willis Rose  
(deceased)

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of

deceased (mo., day, yr.)

December 18, 1864

8. AGE:

Years 83Months 9Days 9

If less than one day

hrs. \_\_\_\_\_

min. \_\_\_\_\_

9. Birthplace

St Marys Co. Md.  
(Town, county, and state)

10. Usual occupation

Housekeeper

11. Industry or business

In daughter's home

12. Name

John Brown

13. Birthplace

unknown

14. Maiden name

Mary Brown

15. Birthplace

unknown

16. Informant

Josephine M. Briggs

Address

4520 - 39th Pl. N. Brentwood17. removal

(Burial, cremation, or removal. Which?)

Date thereof

9-9-48  
(month) (day) (year)

Cemetery or crematory

389 R. 1 Ave N.W.

Location

Washington D.C.

18. Funeral director

Frayer Funeral Home Inc

Address

389 - R. 1 Ave N.W.

19.

(Date recd by registrar)

Sept 9 " 19 48Signature Mrs Jas Severe

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County P. GeorgesCity or town 27 Brentwood Md  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4520 - 39th Pl.  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9 1948, at 6:15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 21 1948, to Sept. 9 1948and that I last saw her alive on September 9 1948Immediate cause of death Chronic Septicemia(Anterio-Scientific Kidney)

DURATION

1 yr.

Due to

Due to

Other conditions

(Include pregnancy within 4 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? ✓

23. SIGNATURE

Wm. H. Miller M.D. M. D. or otherAddress Brentwood, Md Date signed 9-9-48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED  
SEP 13 1948  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09631

Reg. Dist. No. 245

## 1. PLACE OF DEATH:

County Pr. GeorgesCity or town Brentwood  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

3402 - Varnum

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Pr. Geo.City or town Brentwood  
(If outside city or town limits, write RURAL and give nearest town)Street No. 3402 - Varnum  
(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

Lesley L. Rowe

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Melissa J. Rowe6. (c) If alive, give age 57 years7. Birth date of deceased (mo., day, yr.) August 28, 1885

## 8. AGE:

Years

Months

Days

If less than one day

63

..... hrs. .... min.

9. Birthplace Ohio

(Town, county, and state)

10. Usual occupation Retired from Government

## 11. Industry or business

12. Name James H. Rowe13. Birthplace Kentucky14. Maiden name Mary Crawford15. Birthplace Ohio16. Informant Melissa J. RoweAddress 3402 Varnum St., Brentwood, Md.17. Burial Date thereof Sep. 17, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fort Lincoln CemeteryLocation Wash-Balto Blvd & Dist. Line Md.18. Funeral director Wm. J. SpalleyAddress 3200 K.I. Ave., Mt. Rainier, Md.Sep 17 1948 James Sevey

(Date rec'd by Registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 19 48 at 11:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 24 19 48 to Sept 14 19 48  
and that I last saw him alive on Sept 14 19 48

Immediate cause of death

Carcinoma of Stomach

DURATION

9 mos.

Due to

Due to

Other conditions Chronic BronchitisPneumococcal Meningitis

(Include pregnancy within 3 months of death)

3 yrs16 Days

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel J. Sugar M.D. or other4300 Kaywood Dr M.D. or otherAddress Mt. Rainier, Md. Date signed Sept 14, 48

RECEIVED  
SEP 18 1948  
BUREAU A. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 462 09632 142

1. PLACE OF DEATH: Prince Georges  
 County.....  
 City or town..... Chapel Oaks  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 1/2 yrs.  
 Hospital, institution, or street address where death occurred  
 5401 Chapel Oaks Drive  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Maryland County..... Prince Georges  
 City or town..... Chapel Oaks  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 5401 Chapel Oaks Drive  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Lucy Veronica Ryans

## 3. (b) Social Security Number

579-07-8541

4. Sex..... Female  
 5. Color or race..... Negro  
 6. (a) Single, married, widowed, or divorced..... Widowed  
 6. (b) Name of husband or wife..... Henry A. Ryans  
 6. (c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... April 19, 1883  
 8. AGE: Years..... 65 Months..... 4 Days..... If less than one day..... hrs..... min.

9. Birthplace..... Sandy Spring, Md.  
 (Town, county, and state)  
 10. Usual occupation..... Domestic

11. Industry or business.....  
 12. Name..... William Howard Pratt  
 13. Birthplace..... Sandy Spring, Md.  
 14. Maiden name..... Margaret Clark  
 15. Birthplace..... Oliver, W. Va.

16. Informant..... Mrs. Ella Pratt Lewis  
 Address..... Sandy Spring, Md.

17. Burial..... Date thereof..... Sept. 11-1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Mt. Harmony  
 Location..... Wash. D.C.

18. Funeral director..... Robert H. Mc Guire  
 Address..... 1820-9th St., N.W., Wash. D.C.

19. Sept. 9, 1948..... Edna Collins  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... September 8, 1948, at 6:30 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1946 to Sept. 8, 1948 and that I last saw him alive on Sept. 7, 1948.

Immediate cause of death..... Carcinoma of the small intestine with generalized metastases to abdomen.  
 DURATION..... ?  
 Due to.....  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?

23. SIGNATURE..... John W. Robinson, M.D.  
 Address..... 1001 Eastern Ave. Date signed..... 9/8/48

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

243

## 1. PLACE OF DEATH:

County..... Prince Georges  
 City or town..... Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 10 mos., 16 days  
 Hospital, institution, or street address where death occurred:  
 Glenn Dale Sanatorium  
 How long in hospital or institution?..... 10 mos., 16 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... D. C. County.....  
 City or town..... Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 919 - 4th St., S. W.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war..... ✓

## 3. (a) FULL NAME

RANDOLPH SANDERS

## 3. (b) Social Security Number

577-10-4337

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Separated

8. (b) Name of husband or wife Bessie Gurley Sanders

7. Birth date of deceased (mo., day, yr.) (Unknown) 1999

8. AGE: Years Months Days If less than one day  
 About 49 yrs. .... hrs. .... min.

9. Birthplace (see over) Florence, South Carolina  
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business - - - -

FATHER 12. Name Richard Sanders  
 13. Birthplace ? South Carolina

MOTHER 14. Maiden name Millie (Unknown)  
 15. Birthplace ? South Carolina

16. Informant Deceased  
 Address

17. removal (Burial, cremation, or removal. Which?) Date thereof SEPT 19 1948  
 (month) (day) (year)

Cemetery or crematory Washington, D. C.  
 Location Johnson's Funeral Home

18. Funeral director Johnson's Funeral Home  
 Address 2053 SA Oak St. NW

19. 9-19-48 Rowland S. Phillips  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17 to 19 45 at 7:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 31 to 19 47 to Sept 17 19 48

and that I last saw him alive on Sept 17 to 19 48

Immediate cause of death Meningitis, Tuberculosis, Pulmonary Tuberculosis (1 1/2 mo.)

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

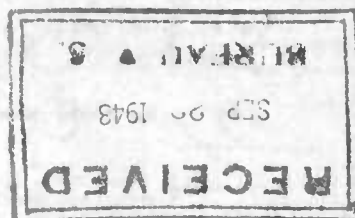
23. SIGNATURE Daniel Leo Pinckney, M.D.

M. D. or other

Address Glenn Dale, Md. Date signed 9/17/48

When admitted, patient stated age as 52.  
Subsequently he showed photostat of  
application for Social Security which  
stated age as about 38, photostat was  
dated 12/3/1936. Photostat returned to  
patient, 11/26/47.

1948  
47  
1999





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

### 1. PLACE OF DEATH:

County Prince Georges  
City or town Cherry  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 5 days  
Hospital, institution, or street address where death occurred:  
Prince Georges Civil Hosp.  
How long in hospital or institution? 5 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Prince Georges  
City or town Ritchie  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 6207 Ritchie Rd.  
(If rural, give LOCATION)  
2. (a) if veteran, name war

### 3. (a) FULL NAME

Grace Evelyn Sasser

### 3. (b) Social Security Number

76

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married

6. (b) Name of husband or wife Charles Sasser

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1894

8. AGE: Years Months Days if less than one day  
53 10 25 hrs. min.

9. Birthplace Maryland Wash. D.C.  
(Town, county, and state)

10. Usual occupation self - Housewife

### 11. Industry or business

12. Name Thomas M. Keech

13. Birthplace St. Mary's Co., Md.

14. Maiden name Rebecca Johnson

15. Birthplace Woodstock, Va.

16. Informant Mr. Charles Sasser

Address 6207 Ritchie Rd. - Wash. 19 - D.C.

17. Burial Date thereof Sept 23, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Epiphany Cem.

Location Farmersville, Maryland

18. Funeral director Ritchie Bros.

Address Upper Marlboro, Md.

19. Sept 22 19 48 Amanda Downey  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Mon. Sept 20 19 48 at 4:15 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 3 19 48 to Sept 20 19 48

and that I last saw her alive on Sept 20 19 48

Immediate cause of death

Carcinoma of

Thomson with

Due to metastases to

Lungs.

Due to

Other conditions Secondary

(Include pregnancy within 8 months of death)

Major findings of operations Carcinoma of

Thomson Date of op. 8-10-48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James B. Sasser D. or other

Address Upper Marlboro, Md. Date signed 9-20-48

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED  
SEP 23 1948  
BUREAU A. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09635

Reg. Dist. No. 243

## 1. PLACE OF DEATH:

County Prince George'sCity or town Collingwood  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 week

Hospital, institution, or street address where death occurred:

Holy Trinity Rectory

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Salbert CountyCity or town J.M. Daniel  
(If outside city or town limits, write RURAL and give nearest town)Street No. None  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Thomas Marshall Scott

## 3. (b) Social Security Number

none

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Flourence Bisle scott

7. Birth date of deceased (mo., day, yr.)

Oct 28, 1880

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

67

hrs.

min.

9. Birthplace

Pittsburg, Pa.  
(Town, county, and state)

10. Usual occupation

Retired Contractor

11. Industry or business

MOTHER FATHER

12. Name

Robert Rodgers scott

13. Birthplace

Pittsburg Pa

14. Maiden name

Elizabeth Seal

15. Birthplace

Orwin Pa

16. Informant

Robert Rodgers scott

Address

57 Bluff Rd, Barrington R.I.

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

BuriedApr 28, 1948

Cemetery or crematory

Christ Church Cemetery

Location

St Michaels, Md

18. Funeral director

Neoncan & Harwood

Address

St. Michaels, Md.19. Sept 26  
(Date rec'd by registrar)44 James Seay

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1948, at 1:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw him... alive on 19...

Immediate cause of death

Hypertensive Heart Disease

DURATION

Due to

Due to

Other conditions

Paralysis Agitans

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury

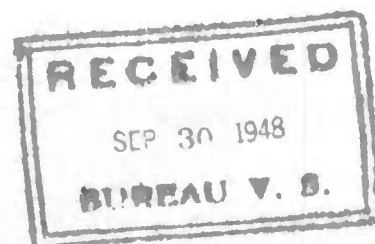
Injured at work?

23. SIGNATURE

John J. Maloney  
Cherub HyltonDep. Med. Examiner

M. D. or other

Date signed 9-27-48



**RECEIVED**

SEP 30 1948

**BUREAU V. S.**

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. *137a*

09636 *248*

### 1. PLACE OF DEATH:

County *Prince Georges*  
City or town *Riverdale, Maryland*  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? *19 days*  
Hospital, institution, or street address where death occurred:  
*Eugene Leland Memorial Hospital*  
How long in hospital or institution? *19 days*

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State *Maryland* County *Prince Georges*  
City or town *Riverdale*  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. *4507 Queensbury Road*  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

*Scott, Mr. Walter F.*

### 3. (b) Social Security Number

4. Sex *male* 5. Color or race *white* 6. (a) Single, married, widowed, or divorced *married*  
6. (b) Name of husband or wife *Emma Frances Scott*  
6. (c) If alive, give age *80* years  
7. Birth date of deceased (mo., day, yr.) *July 28, 1873*  
8. AGE: Years *75* Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
9. Birthplace *New York (Orange County)*  
(Town, county, and state)  
10. Usual occupation *Carpenter*  
11. Industry or business *Retired.*  
12. Name *Ira Francis Scott*  
13. Birthplace *New York*  
14. Maiden name *Susan Seas Roat*  
15. Birthplace *New York*

16. Informant *Hospital records*  
Address *Buail*  
17. (Burial, cremation, or removal. Which?) Date thereof *9-8-48*  
(month) (day) (year)  
Cemetery or crematory *Waxkill Valley Cemetery*  
Location *Walden, New York*  
18. Funeral director *W. W. O. Chandler & Co*  
Address *Riverdale, Md*  
19. *Sept 7* 19*48* *James Seay* Registrar  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept. 6, 1948* at *8:55 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Aug. 18, 1948* to *Sept. 6, 1948*  
and that I last saw him alive on *Sept. 5, 1948*

Immediate cause of death *Uremia* DURATION *4 wks*

Due to *Beriberi Prostatitis hyper trophy* 1 yr.

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE *St. O. Schaffner, Jr. M.D.*  
Address *4404 Queensbury Rd. Riverdale, Md* Date signed *9-6-48*

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 8 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County Prince Geo. Co.City or town Berwyn, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Prince Geo. Co.City or town Berwyn, Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 8320-50th Ave  
(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

GEORGE (NMN) SENGE

## 3. (b) Social Security Number

215-20-27004. Sex M5. Color or race N

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Lillian M. Senge7. Birth date of deceased (mo., day, yr.) Sept 15 - 1872

8. (c) If alive, give age years

8. AGE: Years 75 Months Days If less than one day hrs. min.9. Birthplace Washington D.C.  
(Town, county, and state)10. Usual occupation Retired. Wash. Sch. Board

11. Industry or business

12. Name John Senge13. Birthplace Germany14. Maiden name Mary Beight15. Birthplace Washington D.C.16. Informant William M. SengeAddress 8320-50th Ave. Berwyn, Md.17. Burial Date thereof 9/27/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Fort Lincoln CemeteryLocation Washington D.C.18. Funeral director W. W. Chambers Co.Address Princedale, Md.19. Sept 30 1948 Annandah Downey  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2 Sept 1948 at 11 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JAN 1946 to Sept 1948  
and that I last saw him alive on 30 Aug 1948Immediate cause of death Cerebral Thrombosis  
Bronchiogenic Carcinoma (left) DURATION 10 days  
1 yr +

Due to

Due to

Other condition Generalized  
arterio sclerosis  
(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

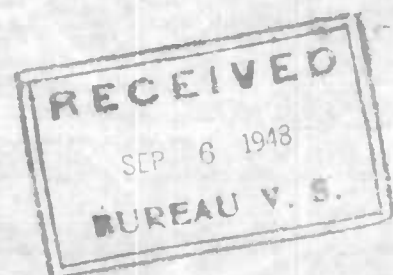
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. W. Chambers M. D. or otherAddress Berwyn, Md. Date signed 9-2-48





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

### 1. PLACE OF DEATH:

County Prince Georges  
City or town Glenn Dale, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 yr., 3 mos., 22 days  
Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
How long in hospital or institution? 1 yr., 3 mos., 22 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County \_\_\_\_\_  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 117 T. Street, N.W.  
(If rural, give LOCATION)  
2. (a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

SHEARLEY LILLIE MAE

### 3. (b) Social Security Number

---

4. Sex Female 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Otis Shearley

8. (c) If alive, give age 26 years

7. Birth date of deceased (mo., day, yr.) May 25, 1921

8. AGE:	Years	Months	Days	If less than one day
<u>27</u>	<u>27</u>	<u>4</u>	<u>1</u>	.....hrs. ....min.

9. Birthplace Prosperity, South Carolina  
(Town, county, and state)

10. Usual occupation Cafeteria Worker

11. Industry or business ---

12. Name Jake Penny

13. Birthplace ? South Carolina

14. Maiden name Eloise Golman

15. Birthplace ? South Carolina

16. Informant Deceased

Address Removal to Wash. D.C.

17. (Burial, cremation, or removal. Which?) Removal to Wash. D.C. Date thereof Sept 18 1948  
(month) (day) (year)

Cemetery or crematory \_\_\_\_\_

Location Ref. G. M. & Guine

18. Funeral director 1520-9050

Address Sept 25, 1948. Rowland S. Phillips

19. (Date rec'd by registrar) \_\_\_\_\_ Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26 19 48, at 3:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/3 19 47, to 9/26 19 48

and that I last saw him or alive on 9/26 19 48

Immediate cause of death pulmonary tuberculosis DURATION 21 mos

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Dates of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Daniel Lee Pincus MD M. D. or other \_\_\_\_\_

Address Glenn Dale, Md. Date signed 9/26/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C.

RECEIVED

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

RECEIVED  
OCT 4 1948  
BUREAU V. S.

105-1050

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

## 1. PLACE OF DEATH:

County..... Prince Georges  
 City or town..... Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 yrs., 9 mos., 21 days  
 Hospital, institution, or street address where death occurred:  
 Glenn Dale Sanatorium  
 How long in hospital or institution? 3 yrs., 9 mos., 21 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... D. C. County.....  
 City or town..... Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3242 M. St., N. W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

ARTHUR E. SHOEMAKER.

3. (b) Social Security Number  
577-12-3201

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Separated  
 6. (b) Name of husband or wife Olive Lee Shoemaker  
 6. (c) If alive, give age 45 years  
 7. Birth date of deceased (mo., day, yr.) August 31, 1892  
 8. AGE: Years 56 Months 0 Days 13 If less than one day hrs. min.

9. Birthplace Chevy Chase, D. C.  
 (Town, County, and state)  
 10. Usual occupation Sheetmetal Worker  
 11. Industry or business  
 12. Name John Shoemaker  
 13. Birthplace Washington, D. C.  
 14. Maiden name Alice King  
 15. Birthplace Washington, D. C.

16. Informant Deceased  
 Address  
 17. Removal (Burial, cremation, or removal, Which?) Date thereof Sept 13, 1948  
 (month) (day) (year)  
 Cemetery or crematory to Washington, D. C.  
 Location W. W. Chambers Co.  
 18. Funeral director W. W. Chambers Co.  
 Address 3071 M. St. N.W. Wash. D. C.  
 19. Sept 13, 1948 Rowland P. Phillips  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13, 1948 at 10:50 A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 22, 1944 to Sept 13, 1948  
 and that I last saw him alive on Sept 13, 1948

Immediate cause of death Coronary Thrombosis DURATION 1 day  
 Due to Pulmonary Tuberculosis 5 yrs 11 mo  
 Due to  
 Other conditions Chronic Nephritis 11 mo  
 Atherosclerosis  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Daniel R. Fineman M.D.  
 M. D. or other  
 Address Glen Dale, Md. Date signed 9/13/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 245

09640

50

## 1. PLACE OF DEATH:

County Prince George's County  
City or town Brentwood Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 weeks

Hospital, institution, or street address where death occurred:

Home

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Prince George'sCity or town Brentwood  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4541 Banner Street  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Susie Simpson

## 3. (b) Social Security Number

4. Sex Female 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 1869 6. (c) If alive, give age 79 years8. AGE: Years 79 Months 0 Days 0 If less than one day 0 hrs. 0 min.9. Birthplace Chester S.C.  
(Town, county, and state)10. Usual occupation NONE

11. Industry or business

12. Name Unknown13. Birthplace Charlotte Johnson14. Maiden name S.C.15. Birthplace S.C.16. Informant John H. GilmoreAddress 4541 Banner St. Brentwood MD17. Removal Date thereof Sept 29 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory 2053 Geo an Ch CrLocation Washington Dc18. Funeral director Johnson & JenkinsAddress 2053 - Geo an Ch CrDate rec'd by Registrar Sept 29 1948 Registrar James Servey

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28 19 48, at 10:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 1 19 48 to Sept 28 19 48and that I last saw her alive on Sept 28 19 48Immediate cause of death Melanotic CarcinomaDue to Carcinoma of breast

Due to

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide none Date ofWhere did injury occur? none (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Injured at work?

Injured at work?

Injured at work?

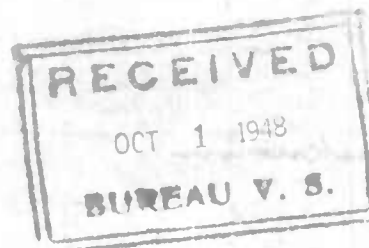
23. SIGNATURE Vernon A. Wilkerson M. D. or otherAddress 61 K St NW Date signed Sept 29, 48

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

09641

245

## 1. PLACE OF DEATH:

County Prince George  
 City or town Sabona Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 years  
 Hospital, institution, or street address where death occurred:  
6709 Conway Avenue  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md. County Prince Geo. Co.  
 City or town Sabona Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 6709 Conway Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

FLORENCE NAOMI SLOTER

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or wife  
 7. Birth date of deceased (mo., day, yr.) March 13, 1917 6.(c) If alive, give age years  
 8. AGE: Years 31 Months 6 Days 1 If less than one day hrs. min.

9. Birthplace Shrapside, Ohio  
 (Town, county, and state)  
 10. Usual occupation Bank Teller  
 11. Industry or business Banking Business  
 FATHER 12. Name Daniel Gully  
 13. Birthplace Comers Creek, West. Va  
 MOTHER 14. Maiden name Myrtle Jackson  
 15. Birthplace Jackson Ridge, Ohio  
 16. Informant Mrs. Bessie L. G. Gully  
 Address 6709 Conway Ave. Sab. Park, Md.  
 17. Burial Date thereof Sept. 16, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rose Hill Cemetery  
 Location Becaine, Ohio  
 18. Funeral director J. Arthur Wacker  
 Address 254 Cannon St. N.W. Sab. Park, D.C.  
 Date rec'd by registrar Sep 14 1948 Registrar James Berry

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14, 1948 at 5:00 A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1948 to Sept. 3, 1948  
 and that I last saw her alive on September 3, 1948  
 Immediate cause of death Addison's Disease DURATION 9 mo.  
 Due to  
 Due to  
 Other conditions  
 (Include pregnancy within 3 months of death)  
 Major findings of operations  
 Date of op.  
 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?  
 23. SIGNATURE Charles T. Carroll M.D.  
Charles T. Carroll, M.D. M. D. or other  
 Address 6801 6th St. N.W. Wash. D.C. Date signed 9/14/48



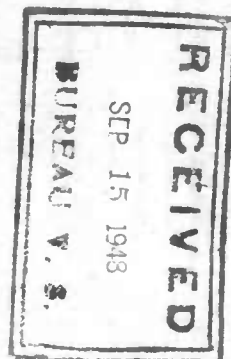
9/14/48

The deceased was visited by  
Dr. Harold Heiges, 1835 Eye St., N.W.  
on September 11, 1948.

My signature is affixed to the  
certificate of death at the  
request of the Deputy Medical  
Examiner, Prince Georges Co., Md.

Charles T. Carroll M.D.

Charles T. Carroll, M.D.  
6801 - 6th St., N.W., Wash., D.C.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09642

Reg. Dist. No. 245

1. PLACE OF DEATH:  
County Prince GeorgesCity or town Mt. Rainier  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Pr. Geo.City or town Mt. Rainier  
(If outside city or town limits, write RURAL and give nearest town)Street No. 5411 Eastern Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

George Edward Sussan

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Edith A. Sussan

7. Birth date of

deceased (mo., day, yr.)

Jan. 15, 1868

6. (c) If alive, give age years

8. AGE:

Years

80

Months

8

Days

8

If less than one day

hrs.

min.

9. Birthplace

Washington, D.C.

(Town, county, and state)

10. Usual occupation

Painter

11. Industry or business

Painter

FATHER

12. Name

Michael C. Sussan

13. Birthplace

Germany

MOTHER

14. Maiden name

Eleanor Gray

15. Birthplace

Washington, D.C.

16. Informant

Chas. E. Sussan

Address

3411 Eastern Ave.

17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof

Sep. 27, 1948

(month) (day) (year)

Cemetery or crematory

Glenwood Cemetery

Location

Wash., D.C.

18. Funeral director

Wm. J. Hally

Address

3200 R. d. Ave., Mt. Rainier

19.

(Date rec'd by registrar)

Sept 2648James Berry

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 23, 1948 at 10:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sep. 22, 1948 to Sep. 23, 1948and that I last saw him alive on Sep. 23, 1948

Immediate cause of death

Gastric hemorrhage

DURATION

1 hr.

Due to

Malignancy of stomach6 mos.

Due to

Other conditions

Cachexia

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Herbert G. Brandes

M. D.

Address

135 R. 1. AVE., N.E.

Date signed

9/23/48WASH., D.C.

RECEIVED

SEP 28 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 234

## 1. PLACE OF DEATH:

County PRINCE GEORGE'S COCity or town Man Hill Ind  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4.5 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Blanche G. THORNE

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

8. Birthplace

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

Date time of

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

19. Date signed by registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County PR. GEORGE'S COCity or town Man Hill Ind  
(If outside city or town limits, write RURAL and give nearest town)Street No. 6760 LIVINGSTON ROAD SE  
(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 20 1948, at 7:00 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 21 1947 to 9-18 1948and that I last saw him alive on 9-18-48

Immediate cause of death

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

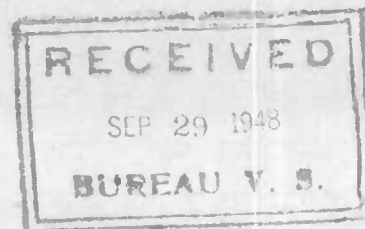
Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09644

Reg. Dist. No. 242

## 1. PLACE OF DEATH:

County Pro Geo Co.City or town Brightseat Md  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 weeks

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

James Tolson

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

Colored

## 6. (a) Single, married, widowed, or divorced

## 6. (b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

June 13, 1948

## 8. AGE:

Years

Months

Days

If less than one day

3

hrs.

min.

## 8. Birthplace

Washington D.C.  
(Town, county, and state)

## 10. Usual occupation

None

## 11. Industry or business

MOTHER FATHER

## 12. Name

Harry Tolson

## 13. Birthplace

Washington D.C.

## 14. Maiden name

Agnes Ringer

## 15. Birthplace

Md

## 16. Informant

Agnes Tolson

## Address

Brightseat Md

## 17. (Burial, cremation, or removal. Which?)

Burial

## Date thereof

Sept 20, 1948  
(month) (day) (year)

## Cemetery or crematory

Methodist

## Location

Blairstown Md

## 18. Funeral director

F. Rosch's sons

## Address

Hyattsville Md

## 19. (Date rec'd by registrar)

Sept 19 48

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Pro GeoCity or town Brightseat  
(If outside city or town limits, write RURAL and give nearest town)

## Street No.

(If rural, give LOCATION)

## 2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1948, at Pro Geo

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

## Immediate cause of death

Acute indigestion

## Due to

Faulty feeding

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Manner of injury

Injured at work?

## 23. SIGNATURE

John D. Maloney ExaminerAddress Cherry Hill Hyattsville Date signed 9-19-48



Wilson

Phone = 1-



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

### 1. PLACE OF DEATH:

County Prince Georges  
City or town Nale  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? transient  
Hospital, institution, or street address where death occurred:  
Route 301  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Sists Widow County Prince Georges  
City or town South Arlington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 3605-25th Street  
(If rural, give LOCATION)  
2. (a) If veteran, name war no ✓

### 3. (a) FULL NAME

Mervin Judson Van Sickle

### 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife  
6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Oct 13, 1930  
8. AGE: Years 17 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Wisconsin  
(Town, county, and state)

10. Usual occupation Apprentice

11. Industry or business sign Painter

12. Name Leslie L. Van Sickle

13. Birthplace Wisconsin

14. Maiden name Martha Allen

15. Birthplace Illinois

16. Informant William C Van Sickle

Address 3605-25th St, South Arlington, Va

17. (Burial, cremation, or removal. Which?) transient Date thereof Sept 19, 1948  
(month) (day) (year)

Cemetery or crematory Cumberland

Location Wisconsin

18. Funeral director F. Gasche Sons

Address Statterville Md

19. Sept 19 48 Registrar Amanda H. Conway

### MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18 1948 at 2:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death Hemorrhage and shock

Due to Crushed chest and pelvis

Due to fracture of skull and right femur

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Accident Date of 9-18-48

Where did injury occur? Nale (County) Prince Georges (State) Md

Injured at home, farm, industry, public place (where?) Route 301

Means of injury car that turned over Injured at work? no

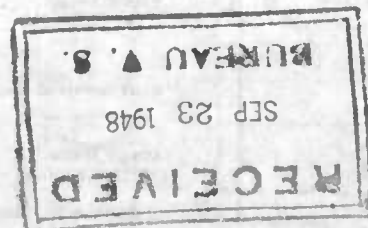
23. SIGNATURE Forestall Md M. D. or other \_\_\_\_\_

Address Forestall Md Date signed 9-18-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

### 1. PLACE OF DEATH:

County Prince Georges  
City or town Glenn Dale, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 yrs., 1 mo., 21 days  
Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
How long in hospital or institution? 2 yrs., 1 mo., 21 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County Washington  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 2454 Snows Court, N. W.  
(If rural, give LOCATION)  
2. (a) If veteran, name war ✓

### 3. (a) FULL NAME

WILLIAM B. WALKER

### 3. (b) Social Security Number

579-32-3339

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Marie Walker

7. Birth date of deceased (mo., day, yr.) March 4, 1880 6. (c) If alive, give age — years

8. AGE: Years Months Days If less than one day  
68 68 6 16 hrs. min.

9. Birthplace Badlands, Wyoming  
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business — — —

FATHER 12. Name Beryl Walker  
13. Birthplace Badlands, Wyoming

MOTHER 14. Maiden name Mag Bentley  
15. Birthplace Badlands, Wyoming

16. Informant Deceased

Address

17. Removal Date thereof Sept 20, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location to Washington, D. C.

18. Funeral director Ambral Boyd

Address 1238-20th St. N.W.

19. Sept 20, 48 Rowland S. Philips  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 20 1948 at 3:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JULY 29, 1946 to SEPT 20, 1948  
and that I last saw him alive on SEPT 20, 1948

Immediate cause of death Pulmonary Tuberculosis DURATION 2 yr. 2 mo.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings at operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel Leo Pinicane MD M. D. or other

Address Glenn Dale Md. Date signed 9-20-48

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 30 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 09647 231

### 1. PLACE OF DEATH:

County Prince George  
City or town Chesely  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2da 5hr 25min  
Hospital, institution, or street address where death occurred:  
Prince George's Gen'l Hosp. 401  
How long in hospital or institution? 2da 5hr 25min

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Prince George  
City or town Chesely  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 5500 Tuxedo Road Tuxedo, Md  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

Franklin D Watts

### 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white single

6. (b) Name of husband or wife Sister Mathie G Owens

7. Birth date of deceased (mo., day, yr.) November 29, 1978

8. AGE: Years Months Days If less than one day

69 9 10 10 hrs. min.

9. Birthplace Maryland  
(Town, county and state)

10. Usual occupation Retired tobacco grower

11. Industry or business

12. Name Jacob Watts

13. Birthplace md

14. Maiden name Mathie G Lowman

15. Birthplace md

16. Informant sister - Mathie G Owens

Address 5500 Tuxedo Rd. Tuxedo, Md

17. Burial Date thereof Sept 13, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Suitland Md

18. Funeral director F. Pasch's sons

Address Hyattsville Md

19. 9/13 19 48 Amanda Downey  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH September 10 19 48 at 2<sup>nd</sup> A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 6 19 48 to Sept 10 19 48

and that I last saw him alive on Sept 9 19 48

Immediate cause of death Arterial constricting

adeno carcinoma of sigmoid obstruction. DURATION 1 week

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Same

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John J. Maloney, MD M. D. or other

Address Chesely-Hyattsville Date signed 9-10-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH 46b

09648

Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County Prince George  
City or town Laurel  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Prince George County HospitalHow long in hospital or institution? 2 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgeCity or town near Laurel  
(If outside city or town limits, write RURAL and give nearest town)Street No. Juniper Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

Howard W. Whitehead

## 3.(b) Social Security Number

## 4. Sex

Male

## 5. Color or race

W

## 6.(a) Single, married, widowed, or divorced

single

## 6.(b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

October 18, 1891

## 6.(c) If alive, give age..... years

## 8. AGE:

Years

Months

Days

If less than one day

56118

hrs.

min.

## 9. Birthplace

Maryland

(Town, county, and state)

## 10. Usual occupation

Farmer

## 11. Industry or business

Farm

## FATHER

## 12. Name

Edward W. Whitehead

## 13. Birthplace

Maryland

## MOTHER

## 14. Maiden name

May Isabelle Ferguson

## 15. Birthplace

Marlboro, Maryland

## 16. Informant

Miss Jennie Whitehead

## Address

Juniper Rd., Laurel, Md.

## 17. Burial

(Burial, cremation, or removal. Which?)

## Date thereof

Sept. 28, 1948

## Cemetery or crematory

Union Cemetery

## Location

Bartonville, Maryland

## 18. Funeral director

Dr. W. H. Danielson

## Address

Laurel, Maryland

## 19. Date of death

Sept. 28, 1948

(Date of death by registrar)

30thAmanda H. H. H. H.

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 26, 1948, at 2:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 18, 1944, to Sept 26, 1948and that I last saw him alive on Sept 26, 1948

## Immediate cause of death

Cancer of stomach  
acute intestinal obstruction

## DURATION

6 mo  
2 days

## Due to

## Due to

## Other conditions

(Include pregnancy within 5 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

Robert S. H. H. H. H.  
462 Main St. Laurel Md.  
Date signed 9/27/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

OCT 1 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of  
age shown on:

FILM No. G 117 OCT 13 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09649

Reg. Dist. No. 230

1. PLACE OF DEATH: **PRINCE GEORGES**  
County.....  
City or town **BELTSVILLE**,  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
**POWDER MILL ROAD.**  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother) **PRINCE GEORGES.**  
State..... County.....  
City or town **BELTSVILLE**,  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. **POWDER MILL RD.**  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3. (a) FULL NAME **MARY ELLEN WILSON.**

3. (b) Social Security Number -

4. Sex **F** 5. Color or race **W** 6. (a) Single, married, widowed, or divorced **DIVORCED.**  
6. (b) Name of husband or wife -  
7. Birth date of deceased (mo., day, yr.) **JULY 3, 1869.** 6. (c) If alive, give age..... years  
8. AGE: Years **79** Months **2** Days **21** It less than one day  
..... hrs. .... min.

9. Birthplace **MD.**  
(Town, county, and state)  
10. Usual occupation **AT HOME.**  
11. Industry or business -  
12. Name **JOHN W. WILSON.**  
13. Birthplace **MD.**  
14. Maiden name **HENRIETTA GOLDEN.**  
15. Birthplace **MD.**

18. Informant **Mrs LILLIAN B OLIFF**  
Address **POWDER MILL RD., BELTSVILLE, MD.**  
17. **BURIAL** Date thereof **SEPT. 1948.**  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory **UNION CEMETERY**  
**BURTONSVILLE, MD.**  
Location

18. Funeral director **Arthur J. Baker**  
Address **505 Washington Blvd., Laurel, Md.**  
19. **September 25<sup>th</sup> 1948**  
(Date rec'd by registrar) **John D. Smith** Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **SEPT 24, 1948, 12:30 P.M.**  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **1930** to **9 24 1948**  
and that I last saw him alive on **9 23 1948**  
Immediate cause of death **Acute Cor Pulmonale**  
**Dehydration**  
Due to **Bronchitis** DURATION **1 day**  
**chronic** **18 yr**  
Due to **chronic** **10 yr**  
Other conditions **Singhly**  
**Malnutrition**  
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....  
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE **B. C. Ryan** M. D. or other  
Address **Baltimore** Date signed **9 25 48**

RECEIVED

SEP 28 1948

BUREAU V. S.

Evidence for change  
of birth-date shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09650

FILM No. G 117 SEP 23 1948 CERTIFICATE OF DEATH

Reg. Dist. No.

245

1. PLACE OF DEATH:

County Prince George  
City or town Hyattsville Md  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 19 years  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md County Aris Lee Co.  
City or town Hyattsville Md  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 5010-44 Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Robert Lee Wilson, sr

3. (b) Social Security Number

4. Sex Male  
5. Color or race white  
6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Josephine Wilson  
6. (c) If alive, give age years  
7. Birth date of deceased (mo., day, yr.) Aug 18, 1896  
8. AGE: Years 52 Months Days If less than one day hrs. min.

9. Birthplace Md  
(Town, county, and state)  
10. Usual occupation watch engineer  
11. Industry or business St Elizabeth Hospital  
12. Name Walter A Wilson  
13. Birthplace Md  
14. Maiden name Viola Barkley  
15. Birthplace Md

16. Informant Josephine Wilson  
Address Hyattsville Md  
17. Burial Date thereof Sept 15, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory St. Lincoln  
Location Colmar Manor Md  
18. Funeral director F. Gasch's sons  
Address Hyattsville Md

19. Sept 14, 1948 Mrs. Gasch, Devere  
(Date read by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12, 1948, at 6:45 A.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-18-48 to 9-12-48  
and that I last saw him alive on 9-12-48

Immediate cause of death Coronary Thrombosis  
DURATION 4 hrs

Due to  
Due to  
Other conditions  
(Include pregnancy within 3 months of death)

Major findings of operations  
Date of op.  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

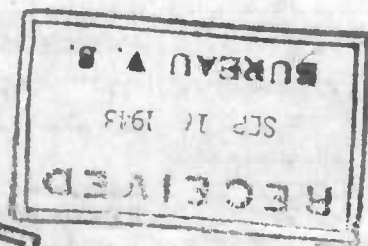
22. VIOLENCE: If death was due to external cause, fill in the following:  
Accident, suicide, or homicide  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE John P. Cam M.D.  
Address Hyattsville Md Date signed 9-14-48  
M. D. or other

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09651

Reg. Diat. No.

239

### 1. PLACE OF DEATH:

County Prince George

City or town Laurel  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 yrs

Hospital, institution, or street address where death occurred:  
20 Talbot ave

How long in hospital or institution?

### 3. (a) FULL NAME

Thomas Joseph Wood

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife Catherine Wood

7. Birth date of deceased (mo., day, yr.) Oct 12, 1871

8. (c) If alive, give age years

8. AGE: Years 76 Months 11 Days 18  
If less than one day hrs. min.

9. Birthplace Prince Geo Co Md  
(Town, county, and state)

10. Usual occupation Labourer

11. Industry or business

12. Name John Wood

13. Birthplace Maryland

14. Maiden name Anna Shipley

15. Birthplace Unknown

16. Informant Grace Miller

Address 9th St Laurel Md

17. Burial Date thereof Oct 4, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St Marys

Location Laurel Md

18. Funeral director Ridgely Selby

Address 401 Wash Ave Laurel Md

Oct 3 19 48 M. Brashears  
(Date rec'd by registrar) Registrar

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Prince Geo

City or town Laurel  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 20 Talbot ave  
(If rural, give LOCATION)

2. (a) If veteran, name war

### 3. (b) Social Security Number

### MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 19 48 at 1<sup>15</sup> A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 27 19 48 to Sept 30 19 48 and that I last saw him alive on Sept 29 19 48

Immediate cause of death Bronchopneumonia DURATION 1 d.

Due to Ureux x infection 2 d.  
w/ enterocolitis

Due to

Other conditions Arteriosclerosis 10 y.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. Brashears M. D. of other

Address Laurel Date signed 10/3/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

